

TO HOSPITAL CERTIFYING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13172

CERTIFICATE OF DEATH

Reg. Dist. No.

13158

1. PLACE OF DEATH o. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 10 HRS.				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL & WARWICK AVES. MEMORIAL HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				
f. STREET ADDRESS BEDFORD ROAD		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First WALTER	Middle Riley	Last ALDERTON			
4. DATE OF DEATH	Month DECEMBER	Day 23	Year 1959			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 19, 1902			
9. AGE (In years from birthday) 57	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired distributor	11. KIND OF BUSINESS OR INDUSTRY Wholesale liquor	12. BIRTHPLACE (State or foreign country) GORMANIA, W.VA.			
13. CITIZEN OF WHAT COUNTRY? U.S.A.	14. FATHER'S NAME ALVEY ALDERTON					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No,	16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	INFORMANT MEMORIAL HOSPITAL	Address CUMBERLAND, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Coronary Artery Disease DUE TO (c) — INTERVAL BETWEEN ONSET AND DEATH — days						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) —						
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —						
20c. TIME OF INJURY Month, Day, Year Hour o. m. — 19 p. m. —		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —	20f. (City or town) —	(County) —	(State) —
21. I certify that I attended the deceased from 12/22/59 , to 12/23/59 , 19 — , that I last saw the deceased alive on 12/22/59 , and that death occurred at 7:20 AM from the causes and on the date stated above. ADDRESS (Street, city or town, state) —						
ACTUAL SIGNATURE <i>R.J. Williams</i>	PHYSICIAN'S NAME (Type) RICHARD J. WILLIAMS M.D.			DATE/SIGNED 12/23/59		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/26/59	22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park	22d. LOCATION (City, town, or county) Cumberland, Maryland	(State) —		
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George Cumberland, Md.	ADDRESS —	24a. REC'D BY REGISTRAR DEC 28 '59	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Koenig</i>			
VS A15 (4) 15M 9/58						

MADELINE

CHARLES

MADELINE

CHARLES

TO HOSPITAL or **ATTENDING PHYSICIAN**: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13173

CERTIFICATE OF DEATH

Reg. Dist. No.

13159

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	c. LENGTH OF STAY IN 1b 6 DAYS	d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
d. NAME OF HOSPITAL (If not in hospital, give street address) MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.		d. STREET ADDRESS 430 VIRGINIA AVE.	
3. NAME OF DECEASED (Type or print)	First HERMAN	Middle S.	Last ATHEY
4. DATE OF DEATH DECEMBER 16 1959	Month Day Year		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 28, 1905
9. AGE (in years last birthday) yrs. 53	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gasoline Service Station Self Emp.	11. BIRTHPLACE (State or foreign country) CUMBERLAND, MARYLAND	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME GEORGE ATHEY	14. MOTHER'S MAIDEN NAME CARRIE HINKLE	INFORMANT MEMORIAL HOSPITAL	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 220-16-7131	INFORMANT MEMORIAL HOSPITAL	Address CUMBERLAND, MARYLAND
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 153.3 DUE TO Carcinoma Sigmoid Colon INTERVAL BETWEEN ONSET AND DEATH approx 1/2 yrs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized metastasis with Cachexia (c) and intestinal obstruction			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, form, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from APRIL 1959 , to Dec 16 1959 , that I last saw the deceased alive on Dec 16 1959 , and that death occurred at 2:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE W. M. Faw Jr.	ADDRESS (Street, city or town, state) M.D. Cumberland Md. DATE SIGNED Dec 16 '59		
PHYSICIAN'S NAME (Type) DR. WYLIE FAW			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12-19-59	22c. NAME OF CEMETERY OR CREMATORIUM Sunset Memorial Park	22d. LOCATION (City, town, or county) (State) Cumberland, Md.
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli	ADDRESS Cumberland, Md.	24a. REC'D BY REGISTRAR DATE DEC 21 '59	24b. REGISTRAR'S SIGNATURE James F. Scarpelli

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13160

Reg. Dist. No.

13174

1. PLACE OF DEATH a. COUNTY Allegany			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland			c. LENGTH OF STAY IN 1b 40 yrs		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 129 Mary Street			e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		
3. NAME OF -DECEASED (Type or print) Gladys Udora Balsley			4. DATE OF DEATH Dec. 3,		
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH July 11, 1894	9. AGE (In years last birthday) 65	IF UNDER 1 YEAR Months 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Ownhome	11. BIRTHPLACE (State or foreign country) Mt Savage Maryland	IF UNDER 24 HRS. Days 0
13. FATHER'S NAME Frank Hergott			14. MOTHER'S MAIDEN NAME Laura Beaver		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	17. INFORMANT Carl M. Balsley I29 Mary St.	Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion					
420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Sclerosis					
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED Dec. 4, 1959	
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-7-59		22c. NAME OF CEMETERY OR CREMATORIUM Hillcrest Burial Park	
22d. LOCATION (City, town, or county) Cumberland, Maryland				(State)	
23. FUNERAL DIRECTOR'S SIGNATURE James F Scarpelli		ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR DATE DEC 7 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Moore	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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REGISTRATION STATE OF ORIGIN - BAGGAGE
MEDICAL EQUIPMENT CERTIFICATE DECODED

1100

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13161

1		Item 20 Film 255 12-16-59 and 1322		Reg. Dist. No.	
1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
Allegany				a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS Railroad Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First CLIFFORD	Middle E.	Last BARNES	4. DATE OF DEATH 12/6/1959 Month 12 Day 6 Year 19
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 2/16/1906	9. AGE (In years last birthday) 53 yrs. IF UNDER 1YEAR Months 53 Days 0 Hours 0 Min. 0 IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Celanese Corp.		11. BIRTHPLACE (State or foreign country) Carles, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Stephen Barnes		14. MOTHER'S MAIDEN NAME Miriam Steele		Address	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-10-2353		17. INFORMANT Mrs. Miriam Barnes, Lonaconing, MD (MOTHER)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxiation DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carbon Monoxide Poisoning DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 30 Min.	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter, nature of injury, in Part I or Part II of item 1b.) Fell asleep in bathtub with gas heater lighted in closed bathroom. Found dead		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour 6:00 a. m. Dec. 6 1959		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) His Home	
20f. (City or town) Lonaconing (County) Alleg. (State) Md.					
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <i>W. O. McLane</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED December 6, 1959	
EXAMINER'S NAME (Type) W. O. McLane, M.D.		Asst DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/9/1959		22c. NAME OF CEMETERY OR CREMATORIALY Memorial Park	
22d. LOCATION (City, town, or county) Frostburg, MD. (State)					
23. FUNERAL DIRECTOR'S SIGNATURE GEORGE EICHORN		ADDRESS LONA CONING, MD.		24a. REC'D BY REGISTRAR DATE DEC 8 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13219

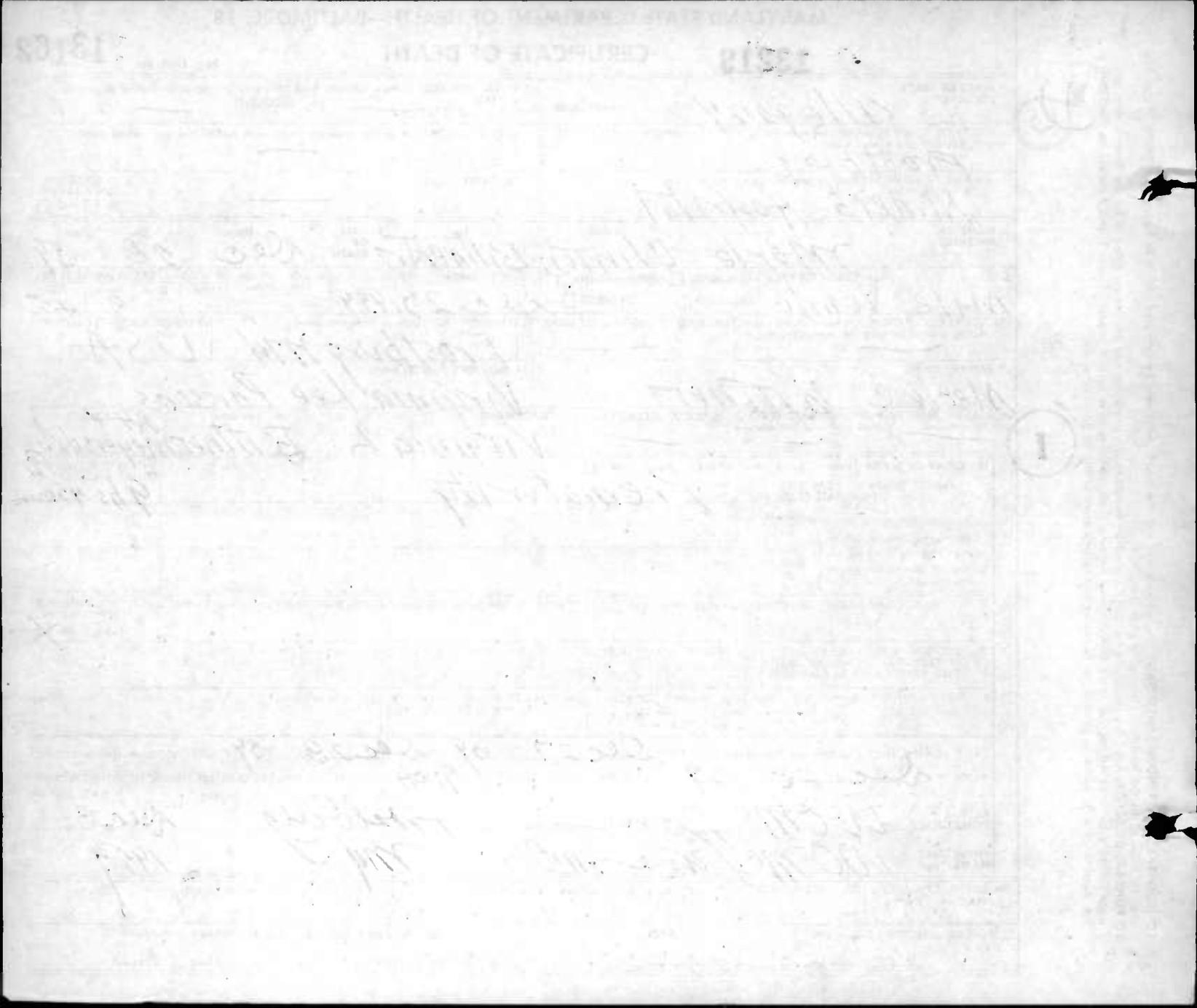
CERTIFICATE OF DEATH

Reg. Dist. No.

13162

TO HOSPITAL may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Allegany</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Penna.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Frostburg</i>	c. LENGTH OF STAY IN lb <i>1b</i>	b. COUNTY <i>—</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Myersdale</i>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Miner's Hospital</i>	d. STREET ADDRESS <i>Rt. # 4</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Merle Clinton Bittner</i>	First <i>Merle</i>	Middle <i>Clinton</i>	Last <i>Bittner</i>
4. DATE OF DEATH <i>Dec 28 1959</i>	Month <i>Dec</i>	Day <i>28</i>	Year <i>1959</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec 27 1959</i>
9. AGE (In years lost birthday) yrs. <i>9 yrs</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>—</i>	11. KIND OF BUSINESS OR INDUSTRY <i>—</i>	12. BIRTHPLACE (State or foreign country) <i>Frostburg MD USA</i>
13. FATHER'S NAME <i>Merle C Bittner</i>	14. MOTHER'S MAIDEN NAME <i>Virginia Lee Parsons</i>	INFORMANT <i>Virginia L. Bittner</i>	Address <i>844 Myersdale</i>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>—</i>	16. SOCIAL SECURITY NO. <i>—</i>	17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>776X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <i>Prematurity</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>Dec 27 1959 19</i>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) <i>Frostburg</i>	
21. I certify that I attended the deceased from <i>Dec 27, 1959</i> , to <i>Dec 28, 1959</i> , that I last saw the deceased alive on <i>Dec 28, 1959</i> , and that death occurred at <i>9:15A M</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>WOMC Lane M.D.</i> ADDRESS (Street, city or town, state) <i>Frostburg</i> DATE SIGNED <i>Dec 28</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>12-29-59</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>White Oak</i>		22d. LOCATION (City, town, or county) <i>Myersdale Rd # 4 Pa</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>H. K. Konkay 203 Northst Meyersdale</i>		ADDRESS <i>20611 May Elizabeth Konkay Penna</i>	
		24a. REC'D BY REGISTRAR DATE <i>DEC 30 '59</i>	
		24b. REGISTRAR'S SIGNATURE <i>Orther S. Kraus</i>	



1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13175 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

13163

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial-cremation, or removal.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
Allegany		a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		b. COUNTY Allegany	
Cumberland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
c. LENGTH OF STAY IN 1b		c. STREET ADDRESS	
48 Yrs.		15 South Smallwood Street	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
15 South Smallwood Street			
3. NAME OF DECEASED (Type or print)		First Harry	Middle Dietrick
		Last Bogler	4. DATE OF DEATH
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
Male		White	8. DATE OF BIRTH
		WIDOWED <input type="checkbox"/>	Feb 12, 1899
		DIVORCED <input type="checkbox"/>	9. AGE (In years from birth) 60 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
Driver		Taxicab	New York State
12. CITIZEN OF WHAT COUNTRY?		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Andrew Bogler		Catherine Dietrick	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT
Yes I.W.W.I.		214-05-6044	Mrs. Mabel Bogler
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Coronary Occlusion	
420.1		DUE TO	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) Coronary Sclerosis with Thrombosis	
		DUE TO	
		(c)	
INTERVAL BETWEEN ONSET AND DEATH 2-3 Hrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
19			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		DATE SIGNED	
ACTUAL SIGNATURE		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> December 13, 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
Burial		12/16/59	
22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county) (State)	
Rose Hill Cemetery		Cumberland Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR DATE DEC 16 '59	
Ruth E. Silcox		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13220

CERTIFICATE OF DEATH

Reg. Dist. No.

13164

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b Lifetime			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) ROBERT		First EARL	Middle BOWEN		
4. DATE OF DEATH Month 12	Year 12	Month Day	Year 1959		
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-17-1894		
9. AGE (In years last birthday) 65 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk	11. KIND OF BUSINESS OR INDUSTRY Prichard Corp.	12. BIRTHPLACE (State or foreign country) Frostburg		
13. CITIZEN OF WHAT COUNTRY U.S.A.	14. MOTHER'S MAIDEN NAME Sophie Pressman				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes	16. SOCIAL SECURITY NO. World War I 216-07-9092	17. INFORMANT (Daughter) Miss Jean Bowen, 37 Washington St., Frostburg, Md.	Address Frostburg, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Coronary Sclerosis Myocardial infarction 2 mo			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m.	20d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 320 FM	20f. (City or town) Frostburg	(County) W.M.D.	(State) Md.
21. I certify that I attended the deceased from Oct 13, 1959 to Dec 12, 1959 , that I last saw the deceased alive on Dec 12, 1959 , and that death occurred at 320 FM , from the causes and on the date stated above.					
ACTUAL SIGNATURE WOMC Lane			ADDRESS (Street, City or town, state) Frostburg Dec 14		
PHYSICIAN'S NAME (Type) WOMC Lane			DATE SIGNED 1959		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12-15-59	22c. NAME OF CEMETERY OR CREMATORIAL Frostburg Memorial Park, Frostburg	22d. LOCATION (City, town, or county) Frostburg	(State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Benah H. Montesano			24a. ADDRESS Hafer Funeral Home	24b. REC'D BY REGISTRAR DEC 18 '59	24c. REGISTRAR'S SIGNATURE Charles S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

EL SHOMITI AR-NYASH PO TIRH YAFET BATE OMAYAM

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13176

CERTIFICATE OF DEATH

13165

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 75 yrs		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION II0 South Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First Elizabeth	Middle Brown	4. DATE OF DEATH Dec. 6, 1959	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 17, 1867	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Ownhome	11. BIRTHPLACE (State or foreign country) Hyndman Pa,	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Gardner	14. MOTHER'S MAIDEN NAME Mary ##### Owens			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT Mrs. James W. Wright II0 South St.	Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 191.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <i>Basal Cell Epithelioma L. Face 10 yrs</i> DUE TO (c) <i>(Very Large)</i>				
INTERVAL BETWEEN ONSET AND DEATH <i>6 mths</i>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from James , 1959, to Dec 6, 1959 , that I last saw the deceased alive on Dec. 6, 1959 , and that death occurred at 5:10 P.M. from the causes and on the date stated above.				ADDRESS (Street, city or town, state) 236 Virginia Ave. Cumberland, Md.
ACTUAL SIGNATURE <i>Clay E. Durrett</i>				DATE SIGNED 13165
PHYSICIAN'S NAME (Type) Clay E. Durrett 236 Virginia Ave. Cumberland, Md.				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12-9-59	22c. NAME OF CEMETERY OR CREMATORIUM Hillcrest Burial Park	22d. LOCATION (City, town, or county) Cumberland, Md.	(State)
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli	ADDRESS Cumberland, Md.	24a. REC'D BY REGISTRAR DATE DEC 10 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Knott	

STATE OF SOUTH DAKOTA DEPARTMENT OF HEALTH - INSURANCE
CERTIFICATE OF DEATH

MARIA TOTH

1910-1981

1910-1981

1910-1981

1910-1981

1910-1981

1910-1981

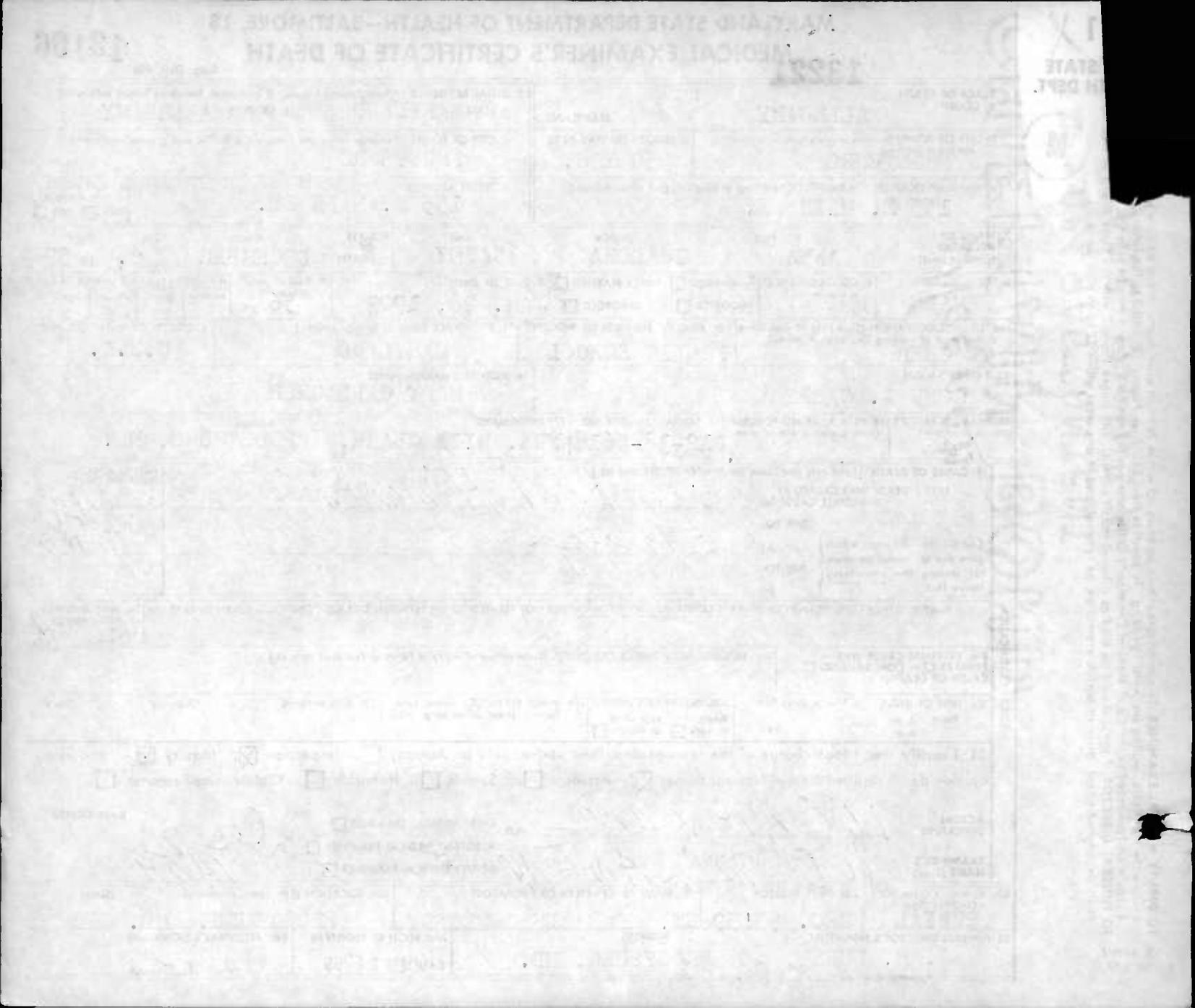
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13221

13166

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG		c. LENGTH OF STAY IN lb 50 YRS.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 155 E. MAIN ST.		e. STREET ADDRESS 155 E. MAIN ST.	
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First ANNA	Middle ISADORA	Last CASEY
4. DATE OF DEATH	Month DECEMBER	Day 6, 1959	Year
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 28, 1903
9. AGE (In years last birthday) 56 yrs.	10. IF UNDER 1 YEAR Months 0 Dots 0	11. IF UNDER 24 HRS. Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TEACHER		10b. KIND OF BUSINESS OR INDUSTRY PUBLIC SCHOOL	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN L. CASEY		14. MOTHER'S MAIDEN NAME MARY GALLAGHER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 212-38-5618	
17. INFORMANT MRS. RITA CLARK,		Address FROSTBURG, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 353.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
Cerebral Hemorrhage Epilepsy - INTERVAL BETWEEN ONSET AND DEATH Sudden. Several years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) FROSTBURG	(County) MD.	(State) MD.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE WO Mc Lane	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
EXAMINER'S NAME (Type) WO Mc Lane	DATE SIGNED Dec 7 1959		
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF DEC. 9 '59	22c. NAME OF CEMETERY OR CREMATORIUM ST. MICHAELS CEMETERY	22d. LOCATION (City, town, or county) FROSTBURG, MD.
VS. A15ME 5M 2/57	ADDRESS	24a. REC'D BY REGISTRAR DEC 11 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus
23. FUNERAL DIRECTOR'S SIGNATURE J. R. DURST			



1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13167

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 3 miles South of Rt. 40		c. LENGTH OF STAY IN 1b Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 3135 Ravenwood Avenue	
3. NAME OF DECEASED (Type or print) THOMAS		First EDWARD	Middle CASSEY
		Last JR.	4. DATE OF DEATH Month December Day 7 Year 1959
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> Aug. 27, 1902
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bus Driver		10b. KIND OF BUSINESS OR INDUSTRY Baltimore Transit	
10c. BIRTHPLACE (State or foreign country) Baltimore Maryland		11. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas Edward Cassedy Sr.		14. MOTHER'S MAIDEN NAME Mary T. Cassedy	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 213-10-2857	
		17. INFORMANT Mrs Louisa I. Cassedy Address 3135 Ravenwood Ave	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion INTERVAL BETWEEN ONSET AND DEATH Sudden			
420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Sclerosis ----- (c) -----			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED December 7, 1959
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.	22b. DATE THEREOF 12/11/59		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22c. NAME OF CEMETERY OR CREMATORIUM BALTIMORE CEMETERY		22d. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND.
23. FUNERAL DIRECTOR'S SIGNATURE <i>John J. Hafer Cumberland, Md.</i>	ADDRESS	24a. REC'D BY REGISTRAR DEC 14 '59	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial or removal.

18191 18191
БИЭКИЛДАВ—НУУЦЫГ ТӨМӨРЧИОД БАШАНД ОХОНДАМ
НТААЗЭЭС ЭССИГҮҮДЭР 8 ЯЙНМААС 1920-НД

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100	101	102	103	104	105	106	107	108	109	110	111	112	113	114	115	116	117	118	119	120	121	122	123	124	125	126	127	128	129	130	131	132	133	134	135	136	137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160	161	162	163	164	165	166	167	168	169	170	171	172	173	174	175	176	177	178	179	180	181	182	183	184	185	186	187	188	189	190	191	192	193	194	195	196	197	198	199	200	201	202	203	204	205	206	207	208	209	210	211	212	213	214	215	216	217	218	219	220	221	222	223	224	225	226	227	228	229	230	231	232	233	234	235	236	237	238	239	240	241	242	243	244	245	246	247	248	249	250	251	252	253	254	255	256	257	258	259	260	261	262	263	264	265	266	267	268	269	270	271	272	273	274	275	276	277	278	279	280	281	282	283	284	285	286	287	288	289	290	291	292	293	294	295	296	297	298	299	300	301	302	303	304	305	306	307	308	309	310	311	312	313	314	315	316	317	318	319	320	321	322	323	324	325	326	327	328	329	330	331	332	333	334	335	336	337	338	339	340	341	342	343	344	345	346	347	348	349	350	351	352	353	354	355	356	357	358	359	360	361	362	363	364	365	366	367	368	369	370	371	372	373	374	375	376	377	378	379	380	381	382	383	384	385	386	387	388	389	390	391	392	393	394	395	396	397	398	399	400	401	402	403	404	405	406	407	408	409	410	411	412	413	414	415	416	417	418	419	420	421	422	423	424	425	426	427	428	429	430	431	432	433	434	435	436	437	438	439	440	441	442	443	444	445	446	447	448	449	450	451	452	453	454	455	456	457	458	459	460	461	462	463	464	465	466	467	468	469	470	471	472	473	474	475	476	477	478	479	480	481	482	483	484	485	486	487	488	489	490	491	492	493	494	495	496	497	498	499	500	501	502	503	504	505	506	507	508	509	510	511	512	513	514	515	516	517	518	519	520	521	522	523	524	525	526	527	528	529	530	531	532	533	534	535	536	537	538	539	540	541	542	543	544	545	546	547	548	549	550	551	552	553	554	555	556	557	558	559	560	561	562	563	564	565	566	567	568	569	570	571	572	573	574	575	576	577	578	579	580	581	582	583	584	585	586	587	588	589	590	591	592	593	594	595	596	597	598	599	600	601	602	603	604	605	606	607	608	609	610	611	612	613	614	615	616	617	618	619	620	621	622	623	624	625	626	627	628	629	630	631	632	633	634	635	636	637	638	639	640	641	642	643	644	645	646	647	648	649	650	651	652	653	654	655	656	657	658	659	660	661	662	663	664	665	666	667	668	669	670	671	672	673	674	675	676	677	678	679	680	681	682	683	684	685	686	687	688	689	690	691	692	693	694	695	696	697	698	699	700	701	702	703	704	705	706	707	708	709	710	711	712	713	714	715	716	717	718	719	720	721	722	723	724	725	726	727	728	729	730	731	732	733	734	735	736	737	738	739	740	741	742	743	744	745	746	747	748	749	750	751	752	753	754	755	756	757	758	759	760	761	762	763	764	765	766	767	768	769	770	771	772	773	774	775	776	777	778	779	770	771	772	773	774	775	776	777	778	779	780	781	782	783	784	785	786	787	788	789	790	791	792	793	794	795	796	797	798	799	800	801	802	803	804	805	806	807	808	809	8010	8011	8012	8013	8014	8015	8016	8017	8018	8019	8020	8021	8022	8023	8024	8025	8026	8027	8028	8029	8030	8031	8032	8033	8034	8035	8036	8037	8038	8039	8040	8041	8042	8043	8044	8045	8046	8047	8048	8049	8050	8051	8052	8053	8054	8055	8056	8057	8058	8059	8060	8061	8062	8063	8064	8065	8066	8067	8068	8069	8070	8071	8072	8073	8074	8075	8076	8077	8078	8079	8080	8081	8082	8083	8084	8085	8086	8087	8088	8089	8090	8091	8092	8093	8094	8095	8096	8097	8098	8099	80100	80101	80102	80103	80104	80105	80106	80107	80108	80109	80110	80111	80112	80113	80114	80115	80116	80117	80118	80119	80120	80121	80122	80123	80124	80125	80126	80127	80128	80129	80130	80131	80132	80133	80134	80135	80136	80137	80138	80139	80140	80141	80142	80143	80144	80145	80146	80147	80148	80149	80150	80151	80152	80153	80154	80155	80156	80157	80158	80159	80160	80161	80162	80163	80164	80165	80166	80167	80168	80169	80170	80171	80172	80173	80174	80175	80176	80177	80178	80179	80180	80181	80182	80183	80184	80185	80186	80187	80188	80189	80190	80191	80192	80193	80194	80195	80196	80197	80198	80199	80200	80201	80202	80203	80204	80205	80206	80207	80208	80209	80210	80211	80212	80213	80214	80215	80216	80217	80218	80219	80220	80221	80222	80223	80224	80225	80226	80227	80228	80229	80230	80231	80232	80233	80234	80235	80236	80237	80238	80239	80240	80241	80242	80243	80244	80245	80246	80247	80248	80249	80250	80251	80252	80253	80254	80255	80256	80257	80258	80259	80260	80261	80262	80263	80264	80265	80266	80267	80268	80269	80270	80271	80272	80273	80274	80275	80276	80277	80278	80279	80280	80281	80282	80283	80284	80285	80286	80287	80288	80289	80290	80291	80292	80293	80294	80295	80296	80297	80298	80299	80300	80301	80302	80303	80304	80305	80306	80307	80308	80309	80310	80311	80312	80313	80314	80315	80316	80317	80318	80319	80320	80321	80322	80323	80324	80325	80326	80327	80328	80329	80330	80331	80332	80333	80334	80335	80336	80337	80338	80339	80340	80341	80342	80343	80344	80345	80346	80347	80348	80349	80350	80351	80352	80353	80354	80355	80356	80357	80358	80359	80360	80361	80362	80363	80364	80365	80366	80367	80368	80369	80370	80371	80372	80373	80374	80375	80376	80377	80378	80379	80380	80381	80382	80383	80384	80385	80386	80387	80388	80389	80390	80391	80392	80393	80394	80395	80396	80397	80398	80399	80400	80401	80402	80403	80404	80405	80406	80407	80408	80409	80410	80411	80412	80413	80414	80415	80416	80417	80418	80419	80420	80421	80422	80423	80424	80425	80426	80427	80428	80429	80430	80431	80432	80433	80434	80435	80436	80437	80438	80439	80440	80441	80442	80443	80444	80445	80446	80447	80448	80449	80450	80451	80452	80453	80454	80455	80456	80457	80458	80459	80460	80461	80462	80463	80464	80465	80466	80467	80468	80469	80470	80471	80472	80473	80474	80475	80476	80477	80478	80479	80480	80481	80482	80483	80484	80485	80486	80487	80488	80489	80490	80491	80492	80493	80494	80495	80496	80497	80498	80499	80500	80501	80502	80503	80504	80505	80506	80507	80508	80509	80510	80511	80512	80513	80514	80515	80516	80517	80518	80519	80520	80521	80522	80523	80524	80525	80526	80527	80528	80529	80530	80531	80532	80533	80534	80535	80536	80537	80538	80539	80540	80541	80542	80543	80544	80545	80546	80547	80548	80549	80550	80551	80552	80553	80554	80555	80556	80557	80558	80559	80560	80561	80562	80563	80564	80565	80566	80567	80568	80569	80570	80571	80572	80573	80574	80575	80576	80577	80578	80579	80580	80581	80582	80583	80584	80585	80586	80587	80588	80589	80590	80591	80592	80593	80594	80595	80596	80597	80

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13177 CERTIFICATE OF DEATH

Reg. Dist. No.

13168

1. PLACE OF DEATH

a. COUNTY

Allegany

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cumberland

c. LENGTH OF STAY IN lb

21 days

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

Sacred Heart Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)

a. STATE

West Virginia

b. COUNTY

Mineral

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Rural

Keyser

85 X-3

d. STREET ADDRESS

e. IS RESIDENCE ON A FARM?

YES NO

3. NAME OF DECEASED
(Type or print)

First
Charles

Middle
R.

Last
Christman

4. DATE OF DEATH

Month
December

Day
21

Year
59

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED

WIDOWED

DIVORCED

8. DATE OF BIRTH

May 25, 1895

9. AGE (In years last birthday)

84 yrs.

IF UNDER 1 YEAR

Months
0

IF UNDER 24 HRS.

Days
0

Hours
0

Min.
0

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Celanese

West Virginia

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Charles H. Christman (deceased)

14. MOTHER'S MAIDEN NAME

Susan ECKARD.

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)
No

16. SOCIAL SECURITY NO.

INFORMANT

Address

Patients chart

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

601X

DUE TO

OUREMIA

INTERVAL BETWEEN
ONSET AND DEATH

2 mos

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause last.

(b)

DUE TO

(c)

Hydrocephalus - Right
Multiple Renal Calculi

10 yrs

10 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

Removal Right Kidney 16 yrs ago (Left)

19. WAS AUTOPSY
PERFORMED?

YES NO

2. MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19

20d. INJURY OCCURRED
While at work Not while at work

20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from **May**, 19**59**, to **21 Dec**, 19**59**, that I last saw the deceased alive on **21 Dec**, 19**59**, and that death occurred at **1128A** from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL
SIGNATURE

PHYSICIAN'S
NAME (Type)

22a. BURIAL, CREMATION,
REMOVAL (Specify)
BURIAL

22b. DATE THEREOF
Dec 24, 1959

22c. NAME OF CEMETERY OR CREMATORIUM
WAXIER Cem.

22d. LOCATION (City, town, or county)
DANVILLE, Md.

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

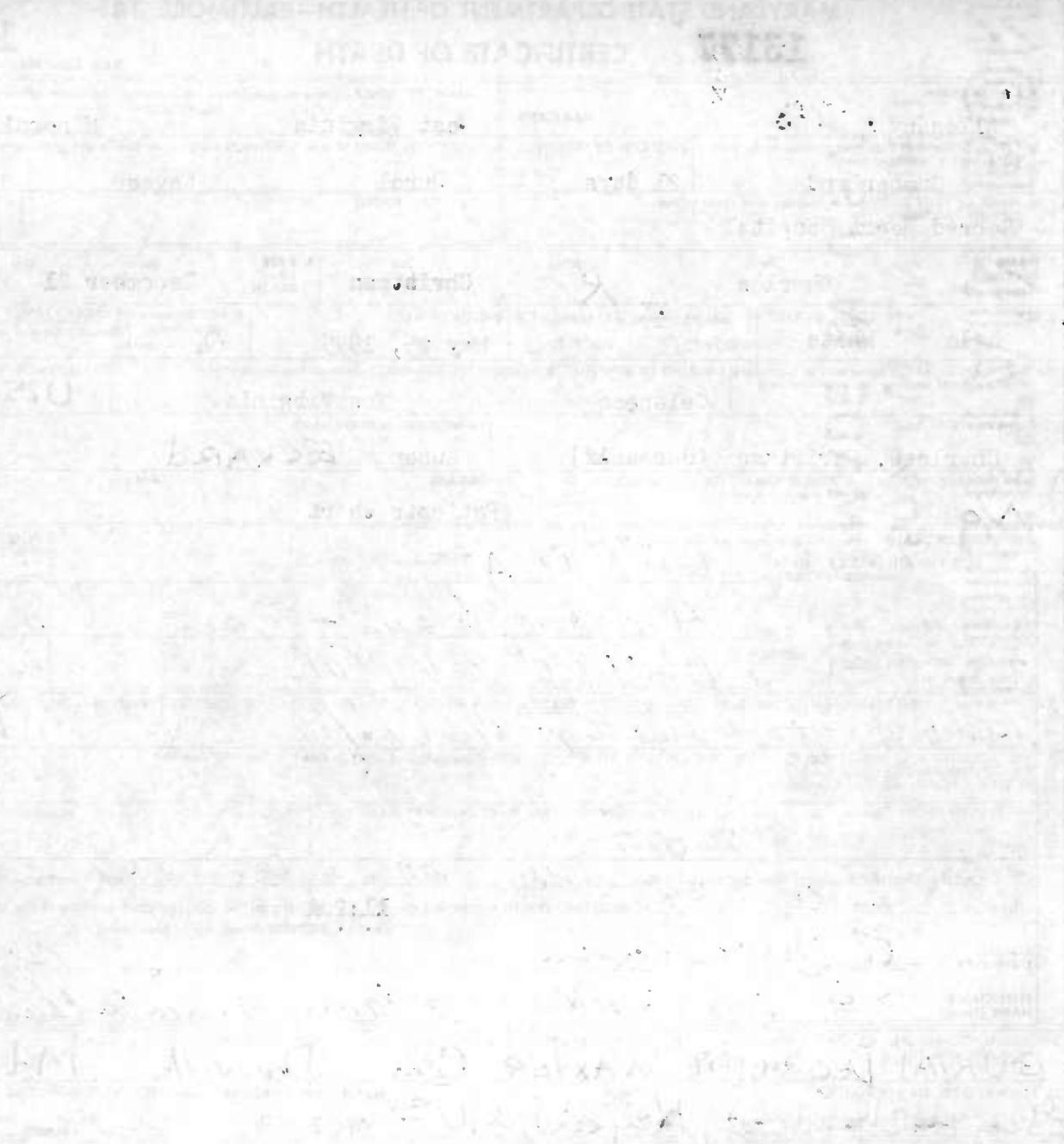
24a. REC'D BY REGISTRAR

DEC 28 '59

24b. REGISTRAR'S SIGNATURE

Arthur S. Kline

17



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13178 CERTIFICATE OF DEATH

13169

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE PENNSYLVANIA	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 5 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street or institution) MEMORIAL HOSPITAL		e. STREET ADDRESS WARRICK & MEMORIAL AVES.,	

3. NAME OF DECEASED (Type or print)	First MARSHALL	Middle Dewey	Last CLINGERMAN	4. DATE OF DEATH DECEMBER 23	Month 19 59	Day	Year
S. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEBRUARY 6	9. AGE (In years last birthday) 60	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Hours 0

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School teacher	10b. KIND OF BUSINESS OR INDUSTRY Public schools	11. BIRTHPLACE (State or foreign country) PENNSYLVANIA	12. CITIZEN OF WHAT COUNTRY? U. S. A.
--	--	--	---

13. FATHER'S NAME CLINGERMAN, ISAAC	14. MOTHER'S MAIDEN NAME MILLER, MARTHA		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO.	INFORMANT	Address MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Terrorism</i>		<i>46 days</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Generalized Arteriosclerosis - Myocardial Infarction</i>		<i>???</i>
(c) <i>Hypertension</i>		<i>???</i>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
<i>Coronary Arteries - Myocardial Infarction</i>		

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Nov 12, 1959</i>		20f. (City or town) Cumberland	(County) Maryland	(State) Pa.
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			

21. I certify that I attended the deceased from Nov 12, 1959 , to Nov 23, 1959 , that I last saw the deceased alive on Nov 22, 1959 , and that death occurred at 6:30 AM , from the causes and on the date stated above.						
ADDRESS (Street, city or town, state) 50 Pershing St., Cumberland, Maryland						

ACTUAL SIGNATURE <i>Samuel Jacobson</i>	M.D. 12/23/59
PHYSICIAN'S NAME (Type) DR. SAMUEL JACOBSON	DATE SIGNED

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec 26, 1959	22c. NAME OF CEMETERY OR CREMATORIUM Fairview	22d. LOCATION (City, town, or county) Bedford Co., Pa.
23. FUNERAL DIRECTOR'S SIGNATURE <i>Lynford L. Conner Everett, Pa.</i>	ADDRESS JAN 4 '60	24a. REC'D BY REGISTRAR Arthur S. Kraus	24b. REGISTRAR'S SIGNATURE

KG 2003 AL 150 12-1993

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13229 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13170

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Savage		c. LENGTH OF STAY IN lb 50 Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Savage		d. STREET ADDRESS Sunnyside		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sunnyside				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First Estella	Middle Conaway	Last	4. DATE OF DEATH December 12	Month 19 59	Day	Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 28, 1889	9. AGE (In years last birthday) 69 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Chaneysville, Pa.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME A. J. Bridges		14. MOTHER'S MAIDEN NAME Resetta Diehl						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO.	17. INFORMANT	Address E. M. Conaway, Mt. Savage, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 420.1		Coronary occlusion					sudden	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first.		(b) Coronary sclerosis					666	
DUE TO								
DUE TO								
(c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					DATE SIGNED Dec. 12, 1959	
EXAMINER'S NAME (Type) Benedict Skitarelic								
22a. BURIAL, CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 15, 1959	22c. NAME OF CEMETERY OR CREMATORIUM Rest Lawn Memorial Park		22d. LOCATION (City, town, or county) Cumberland, Md. RD#1 (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Warren A. Ziegler</i>		ADDRESS Hyndman, Pa.	24a. REC'D BY REGISTRAR DEC 16 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>			

DEPARTMENT OF HEALTH - MARSHALL ISLANDS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11-191

NAME OF PERSON EXAMINED:

SEX: F. AGE: 60

DEATH OCCURRED ON: 10-10-1968

TIME OF DEATH: 10:00 P.M.

PLACE OF DEATH: HOME

CAUSE OF DEATH: HEART DISEASE

EXAMINER'S SIGNATURE: JAMES M. HARRIS

EXAMINER'S ADDRESS: 101 KIRKWOOD AVENUE

EXAMINER'S CITY: PORT VILA

EXAMINER'S STATE: VANUATU

EXAMINER'S ZIP CODE: 98001

EXAMINER'S PHONE NUMBER: (067) 222-1234

EXAMINER'S FAX NUMBER: (067) 222-1234

EXAMINER'S E-MAIL ADDRESS: JAMES.HARRIS@VANUATU.GOV.VU

EXAMINER'S DRIVERS LICENSE NUMBER: 1234567890

EXAMINER'S SOCIAL SECURITY NUMBER: 123-45-6789

EXAMINER'S MEDICAL LICENSE NUMBER: 1234567890

EXAMINER'S CRIMINAL RECORD NUMBER: 1234567890

EXAMINER'S PROFESSIONAL RECORD NUMBER: 1234567890

EXAMINER'S EDUCATIONAL RECORD NUMBER: 1234567890

EXAMINER'S EMPLOYMENT RECORD NUMBER: 1234567890

EXAMINER'S BANK RECORD NUMBER: 1234567890

EXAMINER'S INSURANCE RECORD NUMBER: 1234567890

EXAMINER'S VEHICLE RECORD NUMBER: 1234567890

EXAMINER'S PET RECORD NUMBER: 1234567890

EXAMINER'S OTHER RECORD NUMBER: 1234567890

EXAMINER'S SIGNATURE:

EXAMINER'S ADDRESS:

EXAMINER'S CITY:

EXAMINER'S STATE:

EXAMINER'S ZIP CODE:

EXAMINER'S PHONE NUMBER:

EXAMINER'S FAX NUMBER:

EXAMINER'S E-MAIL ADDRESS:

EXAMINER'S DRIVERS LICENSE NUMBER:

EXAMINER'S SOCIAL SECURITY NUMBER:

EXAMINER'S MEDICAL LICENSE NUMBER:

EXAMINER'S CRIMINAL RECORD NUMBER:

EXAMINER'S PROFESSIONAL RECORD NUMBER:

EXAMINER'S EDUCATIONAL RECORD NUMBER:

EXAMINER'S EMPLOYMENT RECORD NUMBER:

EXAMINER'S BANK RECORD NUMBER:

EXAMINER'S INSURANCE RECORD NUMBER:

EXAMINER'S VEHICLE RECORD NUMBER:

EXAMINER'S PET RECORD NUMBER:

EXAMINER'S OTHER RECORD NUMBER:

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13179 CERTIFICATE OF DEATH

13171

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 11/26/59		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland		d. STREET ADDRESS 15 Market Street	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First John	Middle Samuel	Last Cranor	4. DATE OF DEATH December 26, 1959	Month Day Year	
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 4/25/1883	9. AGE (In years lost birthday) 76 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Salesman		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Samuel Cranor				14. MOTHER'S MAIDEN NAME Sarah Taylor			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 16. SOCIAL SECURITY NO.		INFORMANT P.O.Box 599		Address Cumberland, Md.			
		Allegany County Infirmary Records					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic myocardial degeneration</u> INTERVAL BETWEEN ONSET AND DEATH ? 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral arteriosclerosis.</u> ? (c) <u>Diabetes mellitus</u> ?							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Senile psychosis.</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. 20d. INJURY OCCURRED While Not while p. m. 19 at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 20d. INJURY OCCURRED While Not while p. m. 19 at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 11/26/59, 19, to 12/26/59, 19, that I last saw the deceased alive on 12/24/59, 19, and that death occurred at 6:25P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Dr. James E. McLean 12/26/59 PHYSICIAN'S NAME (Type) Dr. James E. McLean 12/26/59							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/28/59		22c. NAME OF CEMETERY OR CREMATORIAL Hillcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland Md	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer		ADDRESS Cumberland Md		24a. REC'D BY REGISTRAR DEC 30 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hafer	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13180 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 13172

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial; cremation, or removal.

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		d. STREET ADDRESS 696 Fayette St.		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 696 Fayette St.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) JOSEPH HAROLD DIXON		First	Middle	Last	4. DATE OF DEATH Dec. 21,	Month	Day	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 21, 1927	9. AGE (In years last birthday) 32 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fireman		10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) Cumberland, Md.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Harry Dixon		14. MOTHER'S MAIDEN NAME Jessie Hall						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 715-70-5457		17. INFORMANT Harry Dixon		Address Cumberland, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot of Head				INTERVAL BETWEEN ONSET AND DEATH Sudden		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 976X		DUE TO (b)						
		DUE TO (c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE Benedict Skitarelic		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED December 21, 1959				
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 23, 1959		22c. NAME OF CEMETERY OR CREMATORIAL PARK Sunset Memorial Park		22d. LOCATION (City, town, or county) Cumberland, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Byron Knight		ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR DEC 28 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		

STATE OF ILLINOIS
EXAMINER'S CERTIFICATE OF DEATH

NAME OF EXAMINER	ADDRESS	NAME OF DECEASED	AGE	SEX	DEATH DATE	TIME	PLACE
DR. JAMES H. COOPER	111 S. WABASH AV.	JOHN COOPER	65	MALE	APRIL 15, 1911	10:30 A.M.	HOME
REASON FOR EXAMINATION							
DEATH CERTIFICATE							
I, JAMES H. COOPER, M.D., a licensed physician in the State of Illinois, do hereby certify that JOHN COOPER, deceased, was in my care and under my treatment on April 15, 1911, at 10:30 A.M., at his home, 111 S. Wabash Avenue, Chicago, Illinois, and that he died of heart disease, which had been present for many years, and that he died in a natural death.							
JAMES H. COOPER, M.D.							
WITNESSED BY:							
JAMES H. COOPER, M.D.							
APRIL 15, 1911							

1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13250 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13173

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Maryland c. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Vale		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Vale	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 10 Klosterman Ave.		e. STREET ADDRESS 10 Klosterman Ave.	
3. NAME OF DECEASED (Type or print) Mary Margaret Dressman		First	Middle
		Last	4. DATE OF DEATH December 18
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH April 18, 1906
		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) 53 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) Midland, Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Augustine Logsdon	
14. MOTHER'S MAIDEN NAME Rose Burkey		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Anna M. Michael Address 42 Main St. Frostburg, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot wound of Chest		INTERVAL BETWEEN ONSET AND DEATH Sudden	
976X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) DUE TO			
(c) DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>	DATE SIGNED		
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec. 21, 1959	22c. NAME OF CEMETERY OR CREMATORIUM SS. Peter & Paul Cemetery	22d. LOCATION (City, town, or county) (State) Cumberland Maryland
23. FUNERAL DIRECTOR'S SIGNATURE <i>Louis Stein Inc. Cumberland Md.</i>	ADDRESS	24a. REC'D BY REGISTRAR DEC 23 '59	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial-cremation, or removal.

BRUNSWICK—THE MECO SYSTEMS GROUP OF COMPANIES
HAS BEEN EXPANDING ITS MARKET SHARE IN THE
UNITED STATES SINCE 1983.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 13181 Item 11 FilmG254 1-4-60 et
CERTIFICATE OF DEATH

13174

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 5yr, 6mo, 23das.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sylvan Retreat		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Frostburg	
d. STREET ADDRESS Zihlman		d. DATE OF DEATH December 21 1959	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Myra	Middle Lost Evans	4. DATE OF DEATH December	Month Day 21 Year 59
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-17-1879
9. AGE (In years lost birthday) 80 yrs.	10. IF UNDER 1 YEAR Months 0 Days 0	11. IF UNDER 24 HRS. Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
		11. BIRTHPLACE (State or foreign country) Alleg. Co., Maryland	
12. CITIZEN OF WHAT COUNTRY U.S.A.			
13. FATHER'S NAME Thomas B. Evans		14. MOTHER'S MAIDEN NAME Mary Ann Langford	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Mr. Leslie Steele, Zihlman, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 592x		422 Chronic Nephritis	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		450 General arteriosclerosis	
DUE TO (c)		592 Chronic Nephritis	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 304 Senile psychosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 3:45 P.M.	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 21, 1959 to Dec. 21, 1959 , that I last saw the deceased alive on Dec. 21, 1959 , and that death occurred at 3:45 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 49 Greene St., Cumberland, Md. DATE SIGNED James E. McLean	
ACTUAL SIGNATURE James E. McLean		PHYSICIAN'S NAME (Type) James E. McLean 49 Greene St., Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-24-59	
22c. NAME OF CEMETERY OR CREMATORIUM Frostburg Memorial Park		22d. LOCATION (City, town, or county) (State) Frostburg Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Hafer Funeral Home		24a. REC'D BY REGISTRAR DATE DEC 28 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

CERTIFICATE OF DEATH

STATE OF NEW YORK - BUREAU OF VITAL RECORDS

1953

NAME OF DECEASED	AGE	SEX	DEATH DATE	CAUSE OF DEATH

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13231 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13175

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) McCOOLE		c. LENGTH OF STAY IN lb 7 Yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) SAMUEL		First EVERSTINE	Middle FAZENBAKER
4. DATE OF DEATH DEC. 1 19 59		Month DEC.	Doy 1
5. SEX MALE		6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. B. DATE OF BIRTH OCTOBER 2, 1874		9. AGE (In years last birthday) 85 yrs.	10. IF UNDER 1 YEAR Months 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY FARMING	11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME MARCUS MANUEL FAZENBAKER	
14. MOTHER'S MAIDEN NAME ELIZABETH ELLEN BROADWATER		15. WAS DECEASED EVER IN U. S. ARMED FORCES? No. no. (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT MRS. NORA O. FAZENBAKER	
		Address McCOOLE, MARYLAND	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) 451X Cardiac Tamponade			
INTERVAL BETWEEN ONSET AND DEATH 1 hr.			
DUE TO Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause first. (b) Ruptured Dissecting Aneurysm of aorta			
1 hr.			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.		DATE SIGNED December 1, 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF DEC. 4, 1959	
22c. NAME OF CEMETERY OR CREMATORY PHILOS CEMETERY		22d. LOCATION (City, town, or county) WESTERPORT, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE <i>E.S. Board</i>		24a. REC'D BY REGISTRAR DATE DEC 7 '59	
		24b. REGISTRAR'S SIGNATURE <i>Orlina & Krause</i>	

MANUFACTURED BY THE STATE OF SOUTH DAKOTA
INDUSTRIAL COMMISSION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13182

CERTIFICATE OF DEATH

Reg. Dist. No.

13176

1. PLACE OF DEATH a. COUNTY ALLEGANY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MD.		c. LENGTH OF STAY IN 1b 2 HRS. 35 MIN.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X LONACONING, MARYLAND.		d. STREET ADDRESS Charlestown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First CHARLOTTE	Middle B.	Last GARDNER	4. DATE OF DEATH	Month DECEMBER	Day 25	Year 19 59
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPTEMBER 23, 1903	9. AGE (In years last birthday) 56 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HENRY SHOCKEY				14. MOTHER'S MAIDEN NAME CHRISTINE BEAMER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. none		INFORMANT MEMORIAL HOSPITAL		Address CUMBERLAND, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443x DUE TO Cerebral Hemorrhage, severe INTERVAL BETWEEN Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension and arteriosclerotic ONSET AND DEATH 24 hours. (c) Cardio-vascular disease 5 years.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 24 Dec. , 19 59 , to 25 Dec. , 19 59 , that I last saw the deceased alive on 24 Dec. , 19 59 , and that death occurred at 1:05 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE W. Alfred Van Ormer		ADDRESS (Street, city or town, state) 122 S. Ontario St. DATE SIGNED 28 Dec. 59					
PHYSICIAN'S NAME (Type) DR. VAN ORMER							
22a. BURIAL, CREMATION, BURIAL (Specify) Burial		22b. DATE THEREOF 12/27/59		22c. NAME OF CEMETERY OR CREMATORIUM Oak Hill Cemetery		22d. LOCATION (City, town, or county) Lonaconing, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE George Eukhorn Lonaconing Md.				ADDRESS		24a. REC'D BY REGISTRAR DEC 29 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

52151

MANDELIN

GRADY RUM

YANKEE

GRADY RUM, GARDENIA

11 NOV 1953

ALL INFORMATION

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REMEMBER

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REMEMBER

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13183 CERTIFICATE OF DEATH

Reg. Dist. No.

13177

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND,		c. LENGTH OF STAY IN 1b 12 MINUTES	
d. NAME OF HOSPITAL (If not in hospital, give street address) MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ECKHART MINES, MD.	
3. NAME OF DECEASED (Type or print)	First BABY	Middle GIRL	Last GARLITZ
4. DATE OF DEATH	DECEMBER 21 1959		Month Day Year
S. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH DEC. 21, 1959
9. AGE (In years last birthday) yrs. 12	10. IF UNDER 1 YEAR Months 0 Days 0	11. IF UNDER 24 HRS. Hours 0 Min. 12	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) CUMBERLAND, MD.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME IRA A. GARLITZ		14. MOTHER'S MAIDEN NAME MARY LANCASTER	

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO.	INFORMANT MEMORIAL HOSPITAL	Address CUMBERLAND, MARYLAND
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	INTERVAL BETWEEN ONSET AND DEATH about
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 770.0	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Respiratory Failure (Did not expire)	
DUE TO (c) Erythroblastosis Fetalis (Hydrops)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 21 Dec , 19 59 , to 21 Dec , 19 59 , that I last saw the deceased alive on 21 Dec , 19 59 , and that death occurred at 2:05 P.M. , from the causes and on the date stated above.			
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ADDRESS (Street, city or town, state)
David L. Hanson M.D. **13 Grosst. Cumberland 21 Dec 59** DATE SIGNED

ACTUAL SIGNATURE David L. Hanson	PHYSICIAN'S NAME (Type) DR. RANSOM		
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 12-22-1959	22c. NAME OF CEMETERY OR CREMATORIUM ST. ANNS CEM.	22d. LOCATION (City, town, or county) (State) HILTON GARRETT, MD.
23. FUNERAL DIRECTOR'S SIGNATURE Long Newman, Grantsville, Md.	ADDRESS 2060243 XUV3	24a. REC'D BY REGISTRAR DATE JAN 4 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13222

CERTIFICATE OF DEATH

13178

Reg. Dist. No.

1
For death: Page 4

TO ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

may be retained by the hospital or attending physician.

75

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital		d. STREET ADDRESS Street Washington Ext.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) WILBUR ELTON GATTENS		First	Middle	Last	4. DATE OF DEATH 12	Month	Day	Year
S. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 4-15-1900	9. AGE (In years lost birthday) 59 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physician		10b. KIND OF BUSINESS OR INDUSTRY Medical Doctor		11. BIRTHPLACE (State or foreign country) Grafton, W.Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Hugh Gattens		14. MOTHER'S MAIDEN NAME Ella Davis						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT (Daughter) Mrs. William Day, 141 Mt. Pleasant St.,		Address Frostburg, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1		DUE TO		<i>Coronary Occlusion</i>		INTERVAL BETWEEN ONSET AND DEATH 10 min		
Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b)		DUE TO		<i>Coronary Sclerosis - Myocardial Insufficiency</i>		4 years		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Frostburg		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 1953 , 19, to Dec 14, 1959 , that I last saw the deceased alive on Dec 13, 1959 , and that death occurred at Frostburg from the causes and on the date stated above				ADDRESS (Street, city or town, state) Frostburg		DATE SIGNED Dec 14, 1959		
ACTUAL SIGNATURE WOMC Lane								
PHYSICIAN'S NAME (Type) WOMC Lane								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-16-59		22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Frostburg Memorial Park		22d. LOCATION (City, town, or county) Frostburg		(State) Md.
23. FUNERAL DIRECTOR'S SIGNATURE Hafer Funeral Home				24a. REC'D BY REGISTRAR DEC 18 59		24b. REGISTRAR'S SIGNATURE Clara S. Hafer		
				DATE				

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13184

CERTIFICATE OF DEATH

Reg. Dist. No.

13179

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 22 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 45 Years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 062	
3. NAME OF DECEASED (Type or print)	First Paul	Middle William	Last Gilford
4. DATE OF DEATH	Month Dec.	Day 26	Year 1959
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/24, -89
9. AGE (In years last birthday) 70 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Locomotive Engineer	11. KIND OF BUSINESS OR INDUSTRY Western Md	12. BIRTHPLACE (State or foreign country) R.R. Georgia
13. FATHER'S NAME William Gilford	14. MOTHER'S MAIDEN NAME Della Gilford	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. 214-05-8230	17. INFORMANT Mrs. Clara Gilford Wife	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 200.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)	19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH 6 mo
20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21. I certify that I attended the deceased from 24 Nov , 19 58 to 26 Dec , 19 59 , that I last saw the deceased alive on 26 Dec , 19 59 , and that death occurred at 9:00 PM , from the causes and on the date stated above.		
22. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/29/59	22c. NAME OF CEMETERY OR CREMATORIUM Sunset Memorial Park
23. FUNERAL DIRECTOR'S SIGNATURE Ruth E. Silcox		22d. LOCATION (City, town, or county) Cumberland	(State) Maryland (Rural)
ADDRESS Cumberland Maryland		24a. REC'D BY REGISTRAR DEC 30 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Trahan

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13185

CERTIFICATE OF DEATH

Reg. Dist. No.

13180

1. PLACE OF DEATH a. COUNTY ALLEGANY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 7 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X CUMBERLAND			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART HOSPITAL				d. STREET ADDRESS OLDTOWN ROUTE 4		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First GEORGE	Middle H.	Last GRABENSTEIN	4. DATE OF DEATH 12 1 1959	Month Day Year		

5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 11, 1871	9. AGE (In years last birthday) 88 yrs.	IF UNDER 1 YEAR Months 88	IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Self Employed		11. BIRTHPLACE (State or foreign country) MARYLAND - CUMBERLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Justus Grabenstein	14. MOTHER'S MAIDEN NAME Margaret Monday	INFORMANT PT'S CHART	Address
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO. none		

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) ventricular fibrillation arterosclerosis heart disease generalized arterosclerosis		1/2 hour
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)		5 years
		5 years
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m.	Manh. Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)	20f. (City or town) 57 GREENE ST.	(County) (State)

21. I certify that I attended the deceased from 11-24 , 19 37 , to 12-1 , 19 59 , that I last saw the deceased alive on 12-1 , 19 39 , and that death occurred at 1450 M, from the causes and on the date stated above.					
ADDRESS (Street, city or town, state)					
DATE SIGNED 12-2-59					

ACTUAL SIGNATURE <i>L. Brings</i>	M.D.			
PHYSICIAN'S NAME (Type) I. BRINGS, M.D.	57 GREENE ST.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12-4-1959	22c. NAME OF CEMETERY OR CREMATORIUM SS. Peter & Paul Cem.	22d. LOCATION (City, town, or county) Cumberland, Md.	(State)

23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.	ADDRESS	24a. REC'D BY REGISTRAR DEC 4 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Traas
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13181

Reg. Dist. No.

13186

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 22 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF -DECEASED (Type or print)	First MARGARET	Middle 	Last GRIMM
4. DATE OF DEATH	Month Dec.	Day 1	Year 1959
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH June 18 1880
9. AGE (In years last birthday) 79 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife	11. KIND OF BUSINESS OR INDUSTRY 	12. BIRTHPLACE (State or foreign country) VIRGINIA
13. FATHER'S NAME John Grimm	14. MOTHER'S MAIDEN NAME Pauline Decker	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 	
16. SOCIAL SECURITY NO. - - -	17. INFORMANT Mrs. Leatrice Bennett Camb. Md.	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive ASCV disease DUE TO (c)	
INTERVAL BETWEEN ONSET AND DEATH 2 wks.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Fracture right Hip (non-contributing in this case)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. see above		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell as a result of cerebral accident	
20c. TIME OF INJURY Hour 8:30	Month, Day, Year Nov. 9 1959	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home
20f. (City or town) Cumberland, Alleg.	(County) Md.	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE Benedict Skitarelic	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED Dec 1, 1959	
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.	DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 13/3/59	22c. NAME OF CEMETERY OR CREMATORIUM St. Peter & Paul	22d. LOCATION (City, town, or county) Cumberland, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Lewis Stein D.C. Camb. Md.	ADDRESS 	24a. REC'D BY REGISTRAR DATE DEC 4 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Kline

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

DEATH CERTIFICATE
MEDICAL EXAMINER'S OFFICE

1968



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

Reg. Dist. No.

13182

1. PLACE OF DEATH a. COUNTY Allegany 13187 MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Allegany Maryland b. COUNTY Allegany					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 6 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Flintstone		d. STREET ADDRESS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Curtis		First Curtis	Middle Lee	Last Haller	4. DATE OF DEATH December 21, 1959	Month December	Doy 21	Year 1959	
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/18/93		9. AGE (In years less birthday) 60 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired supervisor			10b. KIND OF BUSINESS OR INDUSTRY Celanese		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME Phillip Haller(deceased)				14. MOTHER'S MAIDEN NAME Annabelle				(deceased)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW I 217-10-6292		INFORMANT Patients chart		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-vascular accident DUE TO Atherosclerotic cardio-vascular disease INTERVAL BETWEEN ONSET AND DEATH 4 days Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerotic cardio-vascular disease 2 years (c) 									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
MEDICAL CERTIFICATION	20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)						
	20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 11 - 58 , 19 58 , to 12-21 , 19 59 , that I last saw the deceased alive on 12 - 21 , 19 59 , and that death occurred at 8:35A M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 62 Greene St. DATE SIGNED 12-22-59									
ACTUAL SIGNATURE Ralph W. Ballin M.D. Cumberland, Md.									
PHYSICIAN'S NAME (Type) Ralph W. Ballin, Md.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/23/59		22c. NAME OF CEMETERY OR CREMATORIUM Sunset Memorial Park		22d. LOCATION (City, town, or county) Cumberland Maryland		(State) (Rural)	
23. FUNERAL DIRECTOR'S SIGNATURE Ruth E. Silcox ADDRESS Cumberland Maryland 24a. REC'D BY REGISTRAR DATE DEC 28 '59 24b. REGISTRAR'S SIGNATURE Arthur S. Kline									

273

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13183

Reg. Dist. No.

13183

1. PLACE OF DEATH o. COUNTY Allegany				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN lb 70yrs			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital				e. STREET ADDRESS 910 Gay Street			
3. NAME OF DECEASED (Type or print) Mary A. Hamill				4. DATE OF DEATH I2 Month I4 Day Year 19 59			
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH July 9, 1866	
9. AGE (In years last birthday) 93 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0		11. IF UNDER 24 HRS. Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Ownhome			
11. BIRTHPLACE (State or foreign country) Harper Ferry, W.Va.				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Benjamin Shewbridge				14. MOTHER'S MAIDEN NAME Mary Finn			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-10-7411		17. INFORMANT Harry Shewbridge		Address 527 N. Centre St.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia INTERVAL BETWEEN ONSET AND DEATH 1 Week							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) Arteriosclerotic Cardiovascular disease							
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>				DATE SIGNED December 15, 1959			
EXAMINER'S NAME (Type) Benedict Skitarelic M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION OR REMOVAL (Specify) Burial		22b. DATE THEREOF 12-17-59		22c. NAME OF CEMETERY OR CREMATORIUM Rose Hill Cem.		22d. LOCATION (City, town, or county) Cumberland, Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli Cumberland				ADDRESS		24a. REC'D BY REGISTRAR DEC 21 '59	
						24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

13184

13223

1. PLACE OF DEATH
o. COUNTY

Allegany

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Frostburgc. LENGTH OF Stay IN 1b
*K. S.*d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION
Miner's Hospital2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE

Maryland

b. COUNTY

Allegany

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
22 Frostburg,

d. STREET ADDRESS

78 W. Main Street

e. IS RESIDENCE
ON A FARM?
YES NO

061

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATH

December

19th, 1959

Ann

Lewis

Hanson

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

9. AGE (In years
last birthday)
81 yrs.10. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)
Housewife10b. KIND OF BUSINESS OR INDUSTRY
Own housework11. BIRTHPLACE (State or foreign country)
Maryland12. CITIZEN OF WHAT COUNTRY?
USA

13. FATHER'S NAME

John T. Lewis

14. MOTHER'S MAIDEN NAME

Margaret Thomas

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)

16. SOCIAL SECURITY NO.

INFORMANT

Address 78 W. Main Street

214-10-5072A Miss Ruth Hanson, Frostburg, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

331X

DUE TO

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause last.

(b)

DUE TO

(c)

*Cerebral Hemorrhage
Left Hemiplegia*INTERVAL BETWEEN
ONSET AND DEATH
5 hrs

MEDICAL CERTIFICATION

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?
YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour o. m.
p. m. 1920d. INJURY OCCURRED
While at work Not while at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from *Dec 19, 1959*, to *Dec 19, 1959*, that I last saw the deceased alive on *Dec 19, 1959* and that death occurred at *3:50 PM*, from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL
SIGNATURE*WOMC Lane*

M.D.

*Frostburg Dec 21
1959*PHYSICIAN'S
NAME (Type)*WOMC Lane*22a. BURIAL, CREMATION
REMOVAL (Specify)

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORI

22d. LOCATION (City, town, or county)

(State)

Burial

12-22-59

F' bg. Memorial Park

Frostburg,

Md.

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

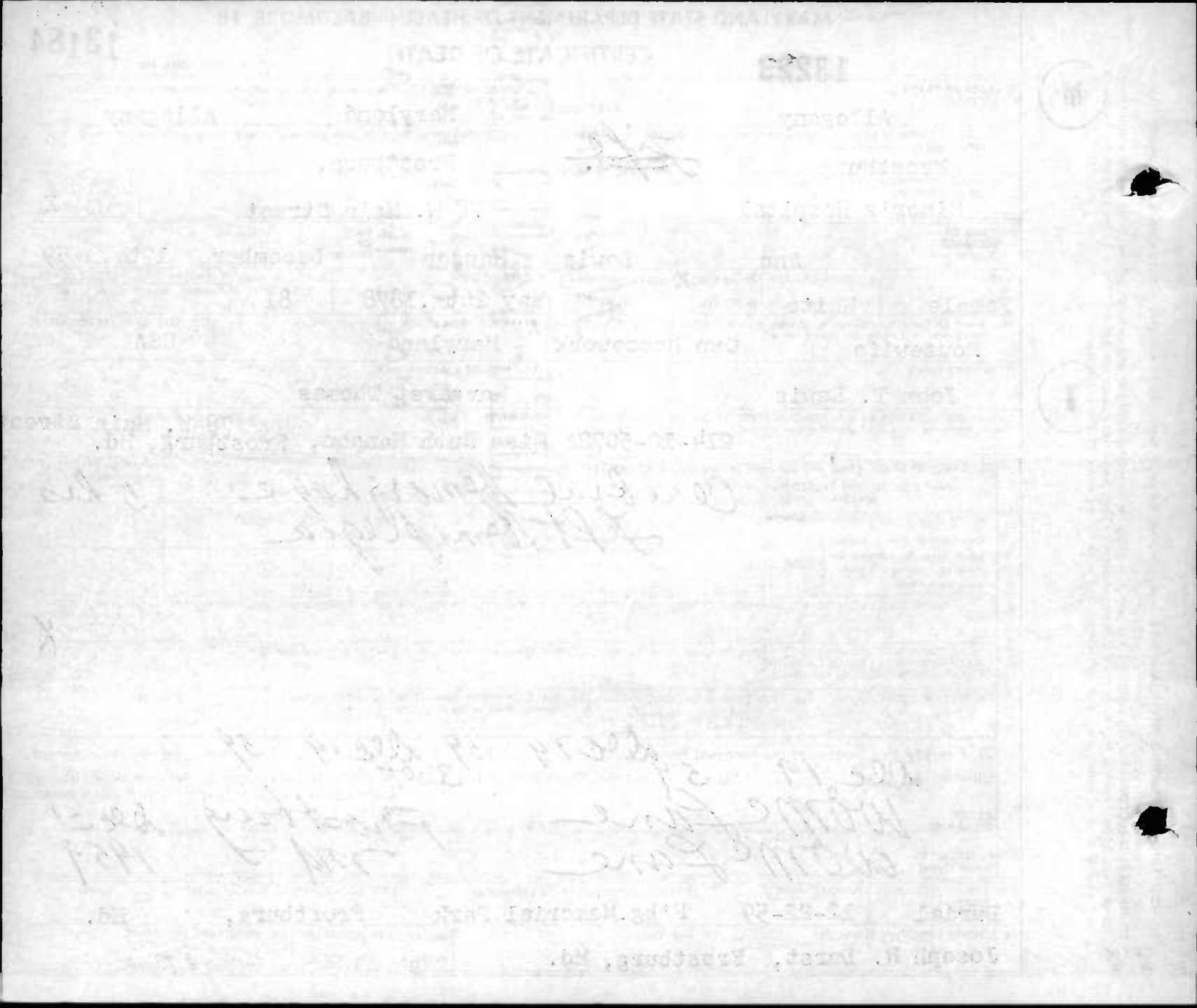
Joseph R. Durst, Frostburg, Md.

24a. REC'D BY REGISTRAR

DATE DEC 23 '59

24b. REGISTRAR'S SIGNATURE

Carlene S. Kline



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

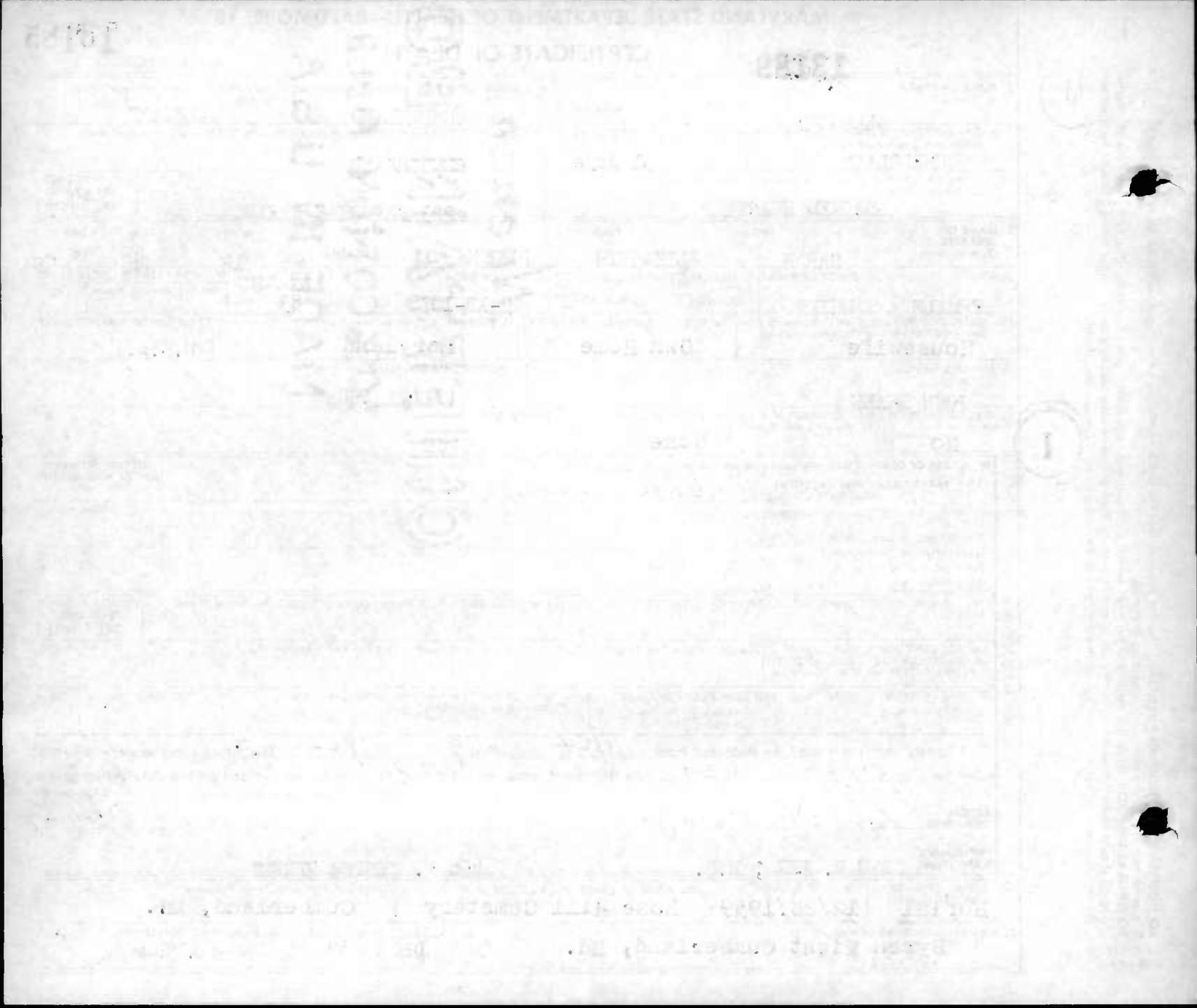
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

13185

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE CUMBERLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 31 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) SARAH		First ELIZABETH	Middle HEARTH
4. DATE OF DEATH 12 21 1959	Month	Day	Year
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 9-12-1876
8. WIDOWED <input type="checkbox"/>	9. DIVORCED <input type="checkbox"/>	10. AGE (In years last birthday) 83 yrs.	11. IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 MRS. Months 12 Days 21 Hours 59 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN SHAW		14. MOTHER'S MAIDEN NAME RACHEL ?SHAW	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT CHART		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 DUE TO Arterosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11/24 , 19 59 , to 12/10/59 , 19 59 , that I last saw the deceased alive on 11/24 , 19 59 , and that death occurred at 1010 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 156 N. CENTER STREET			
ACTUAL SIGNATURE Leo H. Ley Jr.		M.D. _____	
PHYSICIAN'S NAME (Type) Leo H. Ley Q.M.D.		DATE SIGNED 12/26/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/28/1959	
22c. NAME OF CEMETERY OR CREMATORIUM Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Byron Knight		ADDRESS Cumberland, Md.	
		24a. REC'D BY REGISTRAR DATE DEC 29 '59	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kraatz	



1

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial; cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 1319 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13186

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN b Life	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 71 Greene St.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland	
3. NAME OF DECEASED (Type or print) Mary Edna Heims		4. DATE OF DEATH Dec. 3,	Month Day Year 19 59
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 4, 1890
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Cumberland, Md.
13. FATHER'S NAME Frank P. Naughton		14. MOTHER'S MAIDEN NAME Sarah L. Mickel	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	17. INFORMANT Frank J. Naughton
		Address Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION DUE TO 420.1			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CORONARY SCLEROSIS DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>	DATE SIGNED M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Benedict Skitarelic, M.D. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Dec. 3, 1959		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12-7-1959	22c. NAME OF CEMETERY OR CREMATORIUM Umbria Cemetery	22d. LOCATION (City, town, or county) (State) Osceola Mills, Penna.
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George		ADDRESS Cumberland, Md.	24a. REC'D BY REGISTRAR DATE DEC 7 '59
			24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13191

CERTIFICATE OF DEATH

Reg. Dist. No.

13187

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE W. Va.						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 2 days		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Maysville						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print)		First William	Middle Harry	Last Hesse	4. DATE OF DEATH Month 12/ Day 5/ Year 19 59					
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH Sept. 13, 1887	9. AGE (In years lost birthday) yrs. 72	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0		
8. WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own farm		11. BIRTHPLACE (State or foreign country) W. Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Frank Hesse				14. MOTHER'S MAIDEN NAME Linda Goldigen						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		INFORMANT Clarence Hesse, Maysville, W. Va.		Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Cerebral Hemorrhage									INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		DUE TO								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) 13187		(County) 1959	(State) 1959	
21. I certify that I attended the deceased from 13187 , 1959, to 13185 , 1959, that I last saw the deceased alive on 13185 , 1959, and that death occurred at 1:50 AM , from the causes and on the date stated above.									ADDRESS (Street, city or town, state) 452 N. Center St.	
ACTUAL SIGNATURE Leo H. Ley Jr.		M.D. 13187		DATE SIGNED 13187/59						
PHYSICIAN'S NAME (Type) LEO H. LEY JR. M.D.		Cumberland Md.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/7/1959		22c. NAME OF CEMETERY OR CREMATORIUM Turner Cemetery		22d. LOCATION (City, town, or county) Cabins, W. Va.			(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Baline Schaeffer, Petersburg, W. Va.		ADDRESS		24a. REC'D BY REGISTRAR DATE DEC 9 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus				

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rawlings		c. LENGTH OF STAY IN 1b years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Residence		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First MARY	Middle HISE	4. DATE OF DEATH Month December Day 7 Year 59
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1873 April 12, 1974
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Moorefield, West Virginia USA
13. FATHER'S NAME JOHN BARNES		14. MOTHER'S MAIDEN NAME FLORENCE GOODNOW	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? [Yes, no, or unknown]		16. SOCIAL SECURITY NO. none	17. INFORMANT Address James Hise, Rawlings, Maryland
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) Cerebral Hemorrhage INTERVAL BETWEEN ONSET AND DEATH 3 days DUE TO Arteriosclerotic Cardiovascular disease ----- Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause first. (b) ----- DUE TO (c) ----- PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) Fractured Pelvis, right 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) Fell at home and became unconscious	
20c. TIME OF INJURY Hour 4:00 p. m. Month, Day, Year Dec. 4 1959	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) Rawlings, Alleg. (County) Md. (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED December 7, 1959
EXAMINER'S NAME (Type) Benedict Skitarelic M.D.	DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/9/59	22c. NAME OF CEMETERY OR CREMATORIUM Bier Cemetery	22d. LOCATION (City, town, or county) (State) Rawlings, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		ADDRESS	24a. REC'D BY REGISTRAR DATE DEC 9 '59
			24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse the certifying physician, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

ST BROWNS HABITAT ASSESSMENT REPORT FOR THE ST. BROWNS
WILDLIFE MANAGEMENT AREA

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8 & 9-FilmG254-1/15/60-mb

13189

13192

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
Allegany				a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		b. COUNTY Allegany	
Cumberland		3/22/58		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Allegany County Infirmary		635 Columbia Avenue			
3. NAME OF DECEASED (Type or print)		First	Middle	4. DATE OF DEATH	Month Day Year
		Henry	L.	December 23,	19 59
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday) yrs.
Male		White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	4/29/1895	64 74
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Retired: Handy Man				Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Henry Hoenicka		Louise Liabrant		U. S. A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		INFORMANT P. O. Box 599 Address Cumberland, Md.	
(If yes, give war or dates of service)				Allegany County Infirmary Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic myocardial degeneration</u> , INTERVAL BETWEEN ONSET AND DEATH ? X DUE TO					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral arteriosclerosis</u> , ? DUE TO					
(c) <u>Chronic nephritis</u> , ?					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 19. WAS AUTOPSY PERFORMED? <u>Senile psychosis</u> . YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3/22/58</u> , 19_____, to <u>12/23/59</u> , 19_____, that I last saw the deceased alive on <u>12/22/59</u> , 19_____, and that death occurred at _____, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____					
ACTUAL SIGNATURE <u>James E. McLean</u>		49 Green St.		<u>12/23/59</u>	
PHYSICIAN'S NAME (Type) Dr. James E. McLean		Cumberland, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/23/59</u>		22c. NAME OF CEMETERY OR CREMATORIALy <u>St Luke's Cem.</u>	
22d. LOCATION (City, town, or county) <u>Cumberland, Md.</u>				(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein Inc.</u>		ADDRESS <u>Cumb. Md.</u>		24a. REC'D BY REGISTRAR DATE DEC 28 '59	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Mann</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13193

CERTIFICATE OF DEATH

13190

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 12 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First WILLIAM	Middle PINKNEY	Last HOLMES
4. DATE OF DEATH	Month DECEMBER	Day 3	Year 19 59
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOVEMBER 9
9. AGE (In years last birthday) 65 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. Hrs 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TRANSFER CLERK	10b. KIND OF BUSINESS OR INDUSTRY COURT HOUSE	11. BIRTHPLACE (State or foreign country) MARYLAND	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME WILLIAM P. HOLMES	14. MOTHER'S MAIDEN NAME MARION CAVALIER		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]	16. SOCIAL SECURITY NO. 216-07-9091	INFORMANT MEMORIAL HOSPITAL	Address CUMBERLAND, MD.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 501X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO Severe Bronchitis - Interstitial Lymphoma 10y			
Respiratory Failure due to Spontaneous Right Left Pneumothorax 2 wks			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Uremia - nephrosclerosis			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 59 Greene St
20f. (City or town) CUMBERLAND		(County) MD.	(State) MD.
21. I certify that I attended the deceased from 9/22, 19 55 to 3 Dec, 19 59 that I last saw the deceased alive on 3 Dec, 19 59 , and that death occurred at 1:47 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Benevenan		ADDRESS (Street, city or town, state) CUMBERLAND, MD.	
PHYSICIAN'S NAME (Type) DR. WEISMAN		DATE SIGNED 12/4/59	
22a. BURIAL, CREMATION OR REMOVAL (Specify) BURIAL	22b. DATE THEREOF 12-6-59	22c. NAME OF CEMETERY OR CREMATORIAL F'BG. MEMORIAL PARK	22d. LOCATION (City, town, or county) FROSTBURG, (State) MD.
23. FUNERAL DIRECTOR'S SIGNATURE J. R. DURST,	ADDRESS FROSTBURG, MD.	24a. REC'D BY REGISTRAR DATE DEC 7 '59	24b. REGISTRAR'S SIGNATURE Albert J. Grace

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CHIEF COUNSEL FOR DEFENDANT

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13191

13194

CERTIFICATE OF DEATH

Reg. Dist. No.

TO ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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1. PLACE OF DEATH a. COUNTY ALLEGANY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY ALLEGANY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 1HR 45 MIN.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X CUMBERLAND, MARYLAND				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL-MEMORIAL & WARWICK AVES.				d. STREET ADDRESS RT. #4, BOX 132-M. Mexico Farms		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) JEROME		First	Middle	Lost	4. DATE OF DEATH DECEMBER 14 1959	Month	Day	Year
S. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG. 12, 1888		9. AGE (In years last birthday) 71 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired carpenter		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Chest Springs, Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME William F. Johnson				14. MOTHER'S MAIDEN NAME Catherine Conrad				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO.		INFORMANT		Address MEMORIAL HOSPITAL, CUMBERLAND, MD.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute coronary oleumus</i> DUE TO 420.1 INTERVAL BETWEEN ONSET AND DEATH 2 hr.								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? IF EITHER, NOTIFY MEDICAL EXAMINER YES <input type="checkbox"/> NO <input type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from July 1959 to Dec 12 1959 , that I last saw the deceased alive on Dec 12 1959 , and that death occurred at 3:20 AM , from the causes and on the date stated above.								
ADDRESS (Street, city or town, state) M.D. 133 Virginia Ave Cumberland, Md. DATE SIGNED 12/14/59								
ACTUAL SIGNATURE <i>O. G. Himmelwright</i>								
PHYSICIAN'S NAME (Type) DR. O. G. HIMMELWRIGHT								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/17/59		22c. NAME OF CEMETERY OR CREMATORIUM St. Mary's Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George ADDRESS Cumberland, Md. 24a. REC'D BY REGISTRAR DATE DEC 21 '59 24b. REGISTRAR'S SIGNATURE Arthur S. Evans								

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13195

CERTIFICATE OF DEATH

13192

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 13 months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 715 Maryland Avenue		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
d. STREET ADDRESS 715 Maryland Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Bertha		First Moulton	Middle Kidd
4. DATE OF DEATH Dec 10 1959	Month Dec	Day 10	Year 1959
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec 14, 1876
9. AGE (In years from birth) 82	IF UNDER 1 YEAR Months 82	IF UNDER 24 HRS. Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper	10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME John D. Moulton		14. MOTHER'S MAIDEN NAME Margaret Owens	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Non e	17. INFORMANT Mrs. James P. Aaron Jr.
		Address 1092 Braddock Road, Cumberland, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 334X		INTERVAL BETWEEN ONSET AND DEATH 3 mos	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Cerebral Arteriosclerosis		DUE TO 3 yrs	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) M.D. 236 Va. Ave. Cumberland
20f. (City or town) Cumberland		(County) (State) Maryland	
21. I certify that I attended the deceased from Dec 15, 1959 , to Dec 10, 1959 , that I last saw the deceased alive on Dec 8, 1959 , and that death occurred at M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 236 Va. Ave. Cumberland		DATE SIGNED 12/12/59	
ACTUAL SIGNATURE Clayton Bennett			
PHYSICIAN'S NAME (Type) Ruth E. Silcox			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/12/59	22c. NAME OF CEMETERY OR CREMATORIUM New Cathedral Cemetery	22d. LOCATION (City, town, or county) Baltimore
23. FUNERAL DIRECTOR'S SIGNATURE Ruth E. Silcox		ADDRESS Cumberland Maryland	24a. REC'D BY REGISTRAR DEC 14 1959
			24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

01 ЭВОЛЮЦИЯ РОССИЙСКОГО ГОСУДАРСТВА: ИСТОРИЧЕСКАЯ СТАТИСТИКА

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13193

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Vale		c. LENGTH OF STAY IN 1b RURAL and give nearest town)		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY Allegany	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 13 Camp Ground Road				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X La Vale		d. STREET ADDRESS 13 Camp Ground Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First AMOS	Middle A D A M	Last LECHLITER	4. DATE OF DEATH Oct. 26, 1886	Month Dec.	Day 16,	Year 19 59		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 26, 1886	9. AGE (In years lost/birthday) 73 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0	13. IF UNDER 24 HRS. Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Retired millwright		10b. KIND OF BUSINESS OR INDUSTRY Kelly-Tire Co.		11. BIRTHPLACE (State or foreign country) Mineral Co. W. Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Emor Lechliter				14. MOTHER'S MAIDEN NAME Mary C. Largent					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No,		16. SOCIAL SECURITY NO.		17. INFORMANT Miss Catherine Lechliter		Address La Vale 13 Camp Ground Rd.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Failure 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) Hypertension Heart Disease								INTERVAL BETWEEN ONSET AND DEATH Instantly	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Cerebral Arterosclerosis								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		(County)		(State)	
21. I certify that I attended the deceased from 9/8/57 , 1957, to 10/17/59 , 1959, that I last saw the deceased alive on 10/17/59 , 1959, and that death occurred at 10:15 AM from the causes and on the date stated above. ADDRESS (Street, city or town, state) 59 Greene St., Cumberland, Maryland									
ACTUAL SIGNATURE <i>Dr. S. G. Weisman</i>		M.D.		DATE SIGNED <i>12/17/59</i>					
PHYSICIAN'S NAME (Type) Dr. S. G. Weisman		Cumberland, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/19/59		22c. NAME OF CEMETERY OR CREMATORIUM St. Patrick's Cem.		22d. LOCATION (City, town, or county) Cumberland, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George				ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR DATE DEC 21 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEPARTMENT OF STATE - BUREAU OF HUMAN - RELATIONS

CERTIFICATE OF DEATH



X 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13196

CERTIFICATE OF DEATH

Reg. Dist. No.

13194

1. PLACE OF DEATH o. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND,		c. LENGTH OF STAY IN 1b 6 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First ELIZABETH	Middle JANE	Last LEGGE
4. DATE OF DEATH	Month DECEMBER	Day 21	Year 19 59
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOVEMBER 17, 1891
9. AGE (In years lost/birthday) 68 yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Executive secretary	10b. KIND OF BUSINESS OR INDUSTRY American Red Cross	11. BIRTHPLACE (State or foreign country) PENNSYLVANIA
12. CITIZEN OF WHAT COUNTRY? U.S.A.	13. FATHER'S NAME FRANCIS SMITH		
14. MOTHER'S MAIDEN NAME MARTHA SMITH	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 212-38-5491	INFORMANT MEMORIAL HOSPITAL	Address CUMBERLAND, MARYLAND	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 592x DUE TO Mrenna INTERVAL BETWEEN ONSET AND DEATH today			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Nephritis (c) — — —			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) Carcinoma head of pancreas 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.	Month, Doy, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 6/12/59 , 19, to 12/21/59 , 19, that I last saw the deceased alive on 12/21/59 , 19, and that death occurred at 9:20PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE R. J. Williams, M.D.	ADDRESS (Street, city or town, state) Dubois, Allegany County, Maryland		DATE SIGNED 12/28/59
PHYSICIAN'S NAME (Type) DR. R.J.WILLIAMS			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/23/59	22c. NAME OF CEMETERY OR CREMATORIUM Beechwoods Cemetery	22d. LOCATION (City, town, or county) Dubois (State) Penna
23. FUNERAL DIRECTOR'S SIGNATURE Ruth E. Silcox	ADDRESS Cumberland Maryland	24a. REC'D BY REGISTRAR DATE DEC 28 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13197 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13195

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY ALLEGANY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE PENNSYLVANIA		b. COUNTY SOMERSET		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 11 hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BERLIN, RT. #3		d. STREET ADDRESS 75X-3		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF -DECEASED (Type or print) PAUL J. LEONARD		First A.	Middle LEONARD	Last LEONARD	4. DATE OF DEATH 12-26-1959	Month 12	Day 26	Year 1959
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 7-8-46	9. AGE (in years last birthday) 13 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. Hours 0	13. Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY School		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME BRUCE LEONARD				14. MOTHER'S MAIDEN NAME MONICA CALLAHAN				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None		17. INFORMANT CHART		
Address								
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cachexia and Anemia								
DUE TO 916.0								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Burns of body								
DUE TO (c)								
10 Years								
INTERVAL BETWEEN ONSET AND DEATH 6 months								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. Gasoline fire and explosion		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. Ten yrs. ago 1949		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Berlin Somerset Pa.		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
MEDICAL CERTIFICATION								
ACTUAL SIGNATURE <i>Benedict Skitarelic</i> DATE SIGNED								
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.								
M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>								
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>								
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 12/29/59 22c. NAME OF CEMETERY OR CREMATORIUM New Baltimore Cem. 22d. LOCATION (City, town, or county) (State) New Baltimore, Pa.								
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS								
24a. REC'D BY REGISTRAR DATE DEC 28 '59 24b. REGISTRAR'S SIGNATURE Colling S. Kress								

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13196

13198

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 16 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL WARWICK & MEMORIAL AVENUES		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
3. NAME OF DECEASED (Type or print) LOTTIE		First M.	Middle MARTIN
4. DATE OF DEATH DECEMBER 18, 1959.	Month DECEMBER	Day 18	Year 1959.
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1892
9. AGE (In years last birthday) 68 60.	10. IF UNDER 1 YEAR Months 60	11. IF UNDER 24 HRS. Days 60	12. IF UNDER 24 HRS. Hours 60
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Ownhome	11. BIRTHPLACE (State or foreign country) CUMBERLAND, MD.	12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME ALFRED TROXELL	14. MOTHER'S MAIDEN NAME MARY WHETZEL		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pancreomatosis DUE TO 153.0			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Carcinoma of Cervix DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH 4 months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from May 1, 1959 , to Dec 18, 1959 , 1959 that I last saw the deceased alive on Dec 18, 1959 , 1959, and that death occurred at 11 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>D. B. Grove</i>		ADDRESS (Street, city or town, state) M.D. 122 S. Centre St., Cumberland, Md.	
PHYSICIAN'S NAME (Type) DR. DONALD B. GROVE		DATE SIGNED 12-18-59	
22a. BURIAL, CREMATION REMOVAL (Specify) Burial	22b. DATE THEREOF 12-22-59	22c. NAME OF CEMETERY OR CREMATORIUM Frostburg Memorial Park	22d. LOCATION (City, town, or county) Frostburg, Md.
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli		ADDRESS Cumberland, Md.	24a. REC'D BY REGISTRAR DEC 24 '59
			24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

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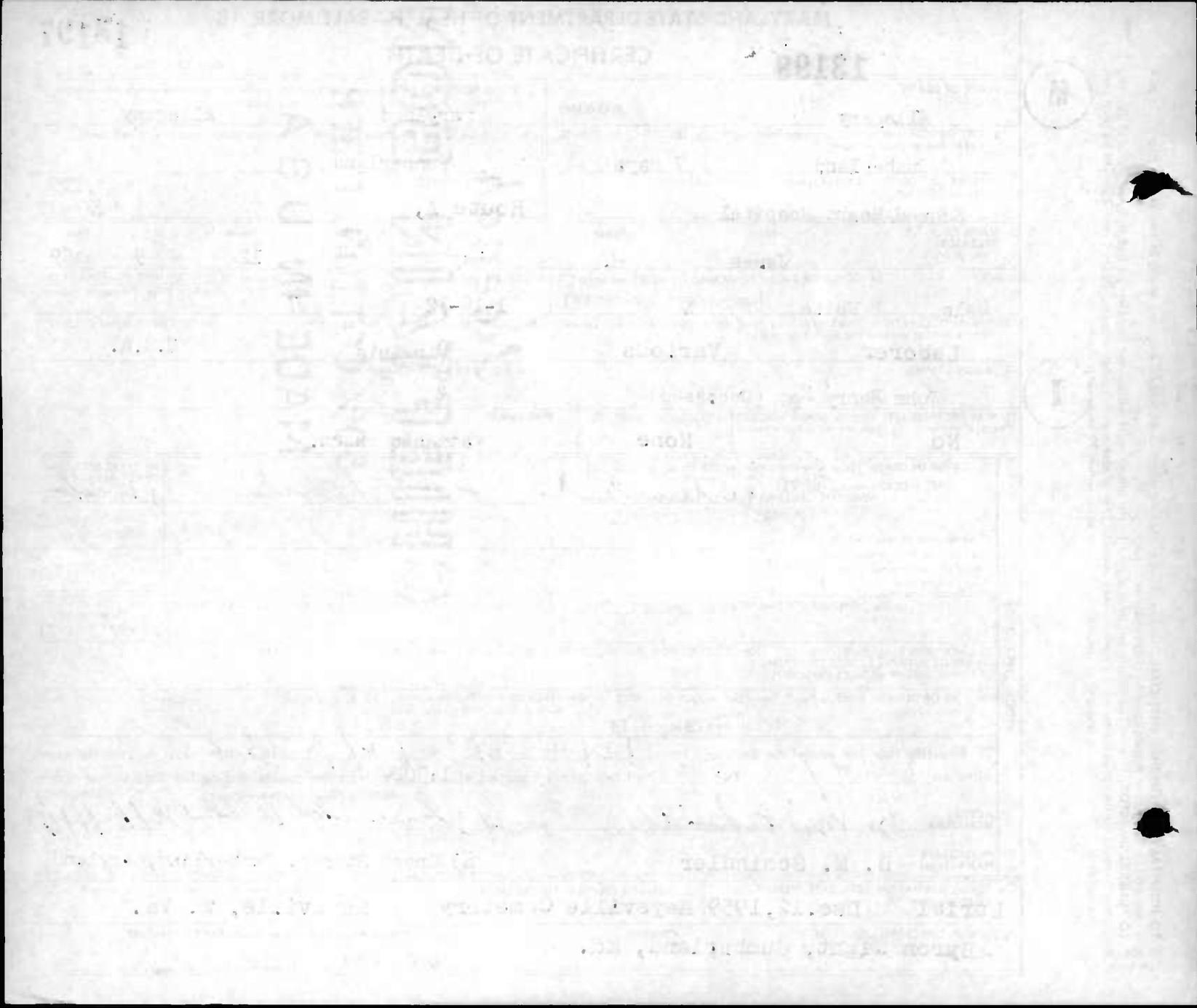
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb 7 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		d. STREET ADDRESS Route 4,		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) James W.		First	Middle	Lost May	4. DATE OF DEATH 12	Month	Day 9	Year 1959
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 1-18-72	9. AGE (In years lost birthday) 87 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Various		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY U.S.A.		
13. FATHER'S NAME John Henry May (Deceased)				14. MOTHER'S MAIDEN NAME ?				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		INFORMANT Patients chart.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 43 Green Street, Cumberland, Maryland		20f. (City or town) (County) (State)		
21. I certify that attended the deceased from 1-21-2 , 19 59 to 1-21-9 , 19 59 , that I last saw the deceased alive on 1-4-91 , 19 59 , and that death occurred at 1:30PM , from the causes and on the date stated above								
ACTUAL SIGNATURE B. M. Schindler		M.D.		ADDRESS (Street, city or town, state) 43 Green Street, Cumberland, Maryland		DATE SIGNED 11/4/11		
PHYSICIAN'S NAME (Type) B. M. Schindler		43 Green Street, Cumberland, Maryland						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 12, 1959		22c. NAME OF CEMETERY OR CREMATORIUM Maysville Cemetery		22d. LOCATION (City, town, or county) Maysville, W. Va. (State)		
23. FUNERAL DIRECTOR'S SIGNATURE Byron Kight, Cumberland, Md.		ADDRESS		24a. REC'D BY REGISTRAR DEC 14 '59		24b. REGISTRAR'S SIGNATURE John S. Thomas		

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of a death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial-cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13198

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital-DOA				d. STREET ADDRESS 240 Welsh Hill	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Russell		First	Middle	Last	4. DATE OF DEATH December 18 1959
5. SEX M		6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 2-13-1910	9. AGE (In years last birthday) 49 yrs.
WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>			IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Recovery Dept.		10b. KIND OF BUSINESS OR INDUSTRY Celanese Corp.		11. BIRTHPLACE (State or foreign country) Ridgely, W.Va.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME George McAbee		14. MOTHER'S MAIDEN NAME Susan Hershberger			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Frostburg, Md. Mrs. Russell McAbee, 240 Welsh Hill	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH 30 Min.			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1		Coronary Occlusion			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		DUE TO Coronary Sclerosis			
(c)		DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Frostburg Memorial Park	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>		DATE SIGNED M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> December 18, 1959			
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.					
22a. BURIAL, CREMATION OR REMOVAL (Specify) Burial		22b. DATE THEREOF 12-21-59	22c. NAME OF CEMETERY OR CREMATORIAL HOME Frostburg Memorial Park		22d. LOCATION (City, town, or county) Frostburg (State) Md.
23. FUNERAL DIRECTOR'S SIGNATURE <i>Benj H. Monteau</i>		23 E. Main, Frostburg, Md.		24a. REC'D BY REGISTRAR Arthur S. Kraus	24b. REGISTRAR'S SIGNATURE
VS. A15ME(5) 5M 9/55		DATE DEC 22 '59			

**19. THE FEDERAL BUREAU OF INVESTIGATION
EX-PRISONER CERTIFICATE OF DEATH**

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
1320 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

13199

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director, forward to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Allegany		b. CITY OR TOWN [If outside corporate limits, write RURAL and give nearest town] Cumberland,		c. LENGTH OF STAY IN 1b 10 Days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE West Virginia		b. COUNTY Preston Co.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 903 Virginia Ave.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Tunnelton, W.Va.		f. STREET ADDRESS Tunnelton,		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) ROY		First METZ		Middle Metz		Last DECEMBER 28		Month 1959			
4. DATE OF DEATH Aug. 25, 1897	5. SEX M.	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 62 yrs.	9. AGE (In years last birthday) 62 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 1 YEAR Hours	13. IF UNDER 24 HRS. Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retire Miner		10b. KIND OF BUSINESS OR INDUSTRY Coal Mine		11. BIRTHPLACE (State or foreign country) Dodson, Maryland		12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME Charles M. Metz		14. MOTHER'S MAIDEN NAME Icerena Spiker									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT John C. Metz 903 Virginia Ave.		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion INTERVAL BETWEEN ONSET AND DEATH sudden											
420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Sclerosis, left -----											
DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Bronchiectasis and Emphysema, marked											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour o. m. p. m.		Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>		DATE SIGNED M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>									
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.		December 28, 1959									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-30-59		22c. NAME OF CEMETERY OR CREMATORIUM Camp Chapel Cem.		22d. LOCATION (City, town, or county) Tunnelton W.Va.					
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli Cumberland, Md.		ADDRESS		24a. REC'D BY REGISTRAR DEC 31 '59		24b. REGISTRAR'S SIGNATURE <i>Carlene S. Kraus</i>					

SI BROMITI—THEM ON THE ROAD TO DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13200

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Scotch Hill				e. STREET ADDRESS Scotch Hill		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Anna	Middle Mae	Last Morton	4. DATE OF DEATH 12/28/1959	Month Day Year 12 28 19		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 2/6/1891	9. AGE (In years lost birthday) 68 yrs.	IF UNDER 1 YEAR Months 68	IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Lonaconing, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Green				14. MOTHER'S MAIDEN NAME Anna Elizabeth James			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Joseph Morton, Lonaconing, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 151x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)				(HUSBAND) Cancer of the stomach INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —					
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day Dec. 28, 1959	Year 1959	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —	20f. (City or town) —	(County) —	(State) —
21. I certify that I attended the deceased from Nov. 1959 to Dec. 28, 1959 that I last saw the deceased alive on Dec. 28, 1959 and that death occurred at 5 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE George Vash M.D.				ADDRESS (Street, city or town, state) 27 Main St. Lonaconing, Md.			
DATE SIGNED —							
22o. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/31/59	22c. NAME OF CEMETERY OR CREMATORIUM Oak Hill Cemetery		22d. LOCATION (City, town, or county) Lonaconing, MD.		
23. FUNERAL DIRECTOR'S SIGNATURE GEORGE EICHORN				ADDRESS LONA CONING, MD.		24a. REC'D BY REGISTRAR DATE DEC 31 '59	24b. REGISTRAR'S SIGNATURE Anna S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAGALYANO STATE GOVERNMENT

CERTIFICATE OF DEATH

MULAN

BENITO JUAN MULAN

LAWRENCE

On the 1st day of January, 1999, I, Lawrence, deceased, was born on the 1st day of January, 1999, at the age of 1 year and 1 month and 1 week old. He died on the 1st day of January, 1999, at the age of 1 year and 1 month and 1 week old.

VIAZON, LEBANON, PHILIPPINES

MAGALYANO STATE GOVERNMENT

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13224

CERTIFICATE OF DEATH

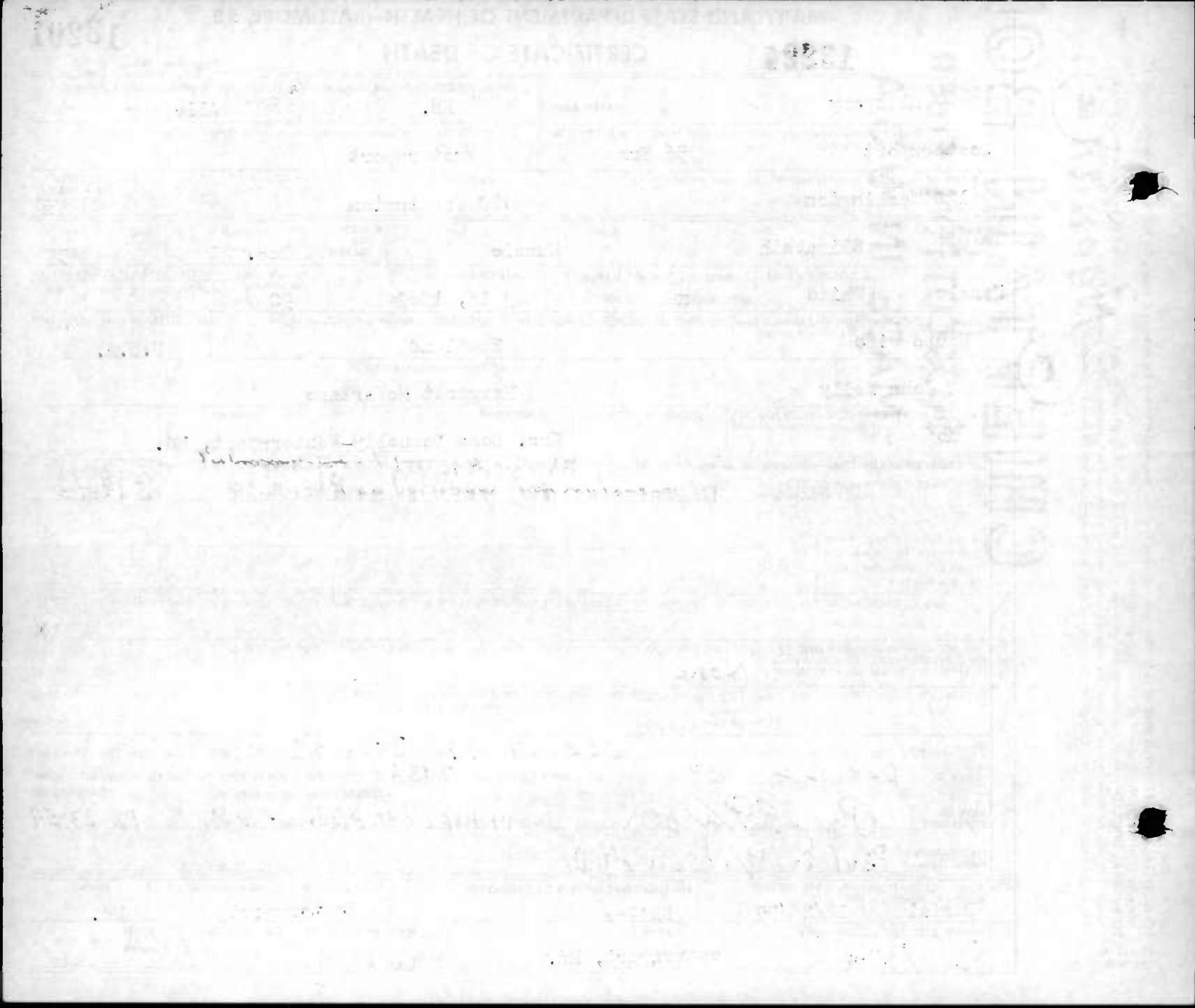
Reg. Dist. No.

13201

TO HOSPITAL or **ATTENDING PHYSICIAN**: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Md. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport		c. LENGTH OF STAY IN 1b 36 Yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 120 Washington		e. STREET ADDRESS 120 Washington	
3. NAME OF DECEASED (Type or print) First Elizabeth Middle Munsie		4. DATE OF DEATH Month Dec. 23 Year 1959	
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 16, 1869
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Scotland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Kelly		14. MOTHER'S MAIDEN NAME Margaret McFarlane	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. INFORMANT Address Mrs. Bess Donnelly-Westernport, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.2 DUE TO Chronic Myocarditis and Myocardi ^l Degeneration not specified as Rheumatic INTERVAL BETWEEN ONSET AND DEATH 5 Years			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) None		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Doy, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 14, 1959, to Dec. 23, 1959, that I last saw the deceased alive on Dec. 22, 1959, and that death occurred at 7:45 AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE Paul R. Wilson		ADDRESS (Street, city or town, state) M.D. 11 Ashfield St. Piedmont, W. Va. DATE SIGNED 12-23-59	
PHYSICIAN'S NAME (Type) Paul R. Wilson M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/26/59	
22c. NAME OF CEMETERY OR CREMATORIAL Philos		22d. LOCATION (City, town, or county) (State) Westernport Md.	
23. FUNERAL DIRECTOR'S SIGNATURE El. Boal		ADDRESS Westernport, Md.	
		24a. REC'D BY REGISTRAR DATE DEC 28 '59	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13202

13202

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 22 Days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Allegany		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sylvan Retreat						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing				
3. NAME OF DECEASED (Type or print) First Lindley		Middle Porter		Last Nichols		4. DATE OF DEATH Month December		Doy 4	Year 1959	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/18/76		9. AGE (In years last birthday) 83 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Silk Mill		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Samuel N. Nichols					14. MOTHER'S MAIDEN NAME Grace Laird					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]					16. SOCIAL SECURITY NO. 215-12-2335		17. INFORMANT Henry Heron "Brother in Law"			Address Lonaconing, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442 Chronic Myocardial Degeneration DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 442X					INTERVAL BETWEEN ONSET AND DEATH ?					
(b) 450 General Arteriosclerosis , - DUE TO					?					
(c) 593 Chronic nephritis					?					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 304 Senile psychosis					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) White at work								
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from Nov. 12 th 1959 to Dec 4 th 1959 , that I last saw the deceased alive on Dec. 3rd , 1959, and that death occurred at 8:45 A.M. from the causes and on the date stated above.										
ACTUAL SIGNATURE James E. McLean ADDRESS (Street, city or town, state) 49 Greene St. DATE SIGNED 12/5/59										
PHYSICIAN'S NAME (Type) James E. McLean, M.D.		49 Greene Street, Cumberland, Md.								
22a. BURIAL, CREMATION, BURIAL (Specify) Burial		22b. DATE THEREOF 12/8/59		22c. NAME OF CEMETERY OR CREMATORIUM Oak Hill Cemetery		22d. LOCATION (City, town, or county) Lonaconing, Md. (State)				
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn		ADDRESS Lonaconing, Md.		24a. REC'D BY REGISTRAR DATE DEC 8 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Times				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE DEPARTMENT OF HEALING - GARNERINGS

CERTIFICATE OF DEATH

DEATH CERTIFICATE

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18												13203		13203	
CERTIFICATE OF DEATH												Reg. Dist. No.			
1. PLACE OF DEATH o. COUNTY ALLEGANY						2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND						b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			c. LENGTH OF STAY IN 1b 20 DAYS			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			d. STREET ADDRESS 22 ARCH STREET			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL (If not in hospital, give name and address) OR INSTITUTION WARWICK & MEMORIAL MEMORIAL HOSPITAL AVES.,		Last Month Day Year THOMAS F. NORTON DECEMBER 8 19 59													
3. NAME OF DECEASED (Type or print)		First THOMAS		Middle F.		4. DATE OF DEATH DECEMBER 15 1879		9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH DECEMBER 15 1879		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Conductor Railroad		10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME JAMES NORTON		14. MOTHER'S MAIDEN NAME MARY L. WINNER													
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		INFORMANT		Address MEMORIAL HOSPITAL CUMBERLAND, MARYLAND									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]												INTERVAL BETWEEN ONSET AND DEATH 3 weeks			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4222 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } { DUE TO (b) <i>Thrombosis</i> DUE TO (c) <i>Myocarditis & Decompensation 3 mos</i>															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)					
21. I certify that I attended the deceased from <i>Sept 10, 1959</i> , to <i>Dec 8, 1959</i> , that I last saw the deceased alive on <i>Dec. 8, 1959</i> , and that death occurred at <i>1:10 PM</i> , from the causes and on the date stated above.												ADDRESS (Street, city or town, state) Clay & Durrett M.D. 236 Valley Cumberland, Md.			
ACTUAL SIGNATURE <i>Clay & Durrett M.D. 236 Valley Cumberland, Md.</i>												DATE SIGNED 17/12/59			
PHYSICIAN'S NAME (Type)		DR. JAMES X. MAXWELL CLAY & DURRETT													
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-11-1959		22c. NAME OF CEMETERY OR CREMATORIUM St. Mary's Cemetery		22d. LOCATION (City, town, or county) Cumberland, Md.		(State)							
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.		ADDRESS		24a. REC'D BY REGISTRAR DEC 14 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Evans</i>		DATE							

WADDELL

CHURCH

WADDELL

CHURCH

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WADDELL WADDELL

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13204

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 80 Yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 413 Maryland Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MARGARET HELEN O'NEIL		Last O'NEIL	4. DATE OF DEATH Dec. 28, 1959
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH July 11, 1879
9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0	11. IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress		10b. KIND OF BUSINESS OR INDUSTRY Ladies clothing	11. BIRTHPLACE (State or foreign country) Cumberland, Md.
13. FATHER'S NAME Thomas O'Neil		14. MOTHER'S MAIDEN NAME Margaret Moran	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? [Yes, no, or unknown] No		16. SOCIAL SECURITY NO.	17. INFORMANT Mrs. Walter Fraley
		Address Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO CORONARY OCCLUSION INTERVAL BETWEEN Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CORONARY SCLEROSIS ONSET AND DEATH DUE TO (c) SUDDEN -----			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED December 29, 1959
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.	DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/31/1959	22c. NAME OF CEMETERY OR CREMATORIUM St. Patricks Cem.	22d. LOCATION (City, town, or county) Cumberland, Md. (State)
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George		ADDRESS Cumberland, Md.	24a. REC'D BY REGISTRAR DEC 31 '59
			24b. REGISTRAR'S SIGNATURE <i>Arthur L. Koenig</i>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay occurs, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Forward to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A1SME(5)
5M 9/55

REGULAR EXAMINER CERTIFICATE OF GRADE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13205

CERTIFICATE OF DEATH

Reg. Dist. No.

13205

TO ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 3 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First JOHN	Middle LOUIS	Last Lewis
4. DATE OF DEATH	Month DECEMBER	Day 8	Year 1959
S. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 1881
		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	FEB. 4, 1881
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) President		10b. KIND OF BUSINESS OR INDUSTRY BAKERY Ort Bros	
10c. BIRTHPLACE (State or foreign country) MARYLAND, Frostburg		11. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME LEWIS ORT (DECEASED)		14. MOTHER'S MAIDEN NAME CAROLINA Turner (DECEASED)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. INFORMANT	
PATIENTS CHART			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO congestive heart failure INTERVAL BETWEEN ONSET AND DEATH 8 weeks			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriovenous heart disease DUE TO 8 weeks			
(c) generalized arteriosclerosis 1 year			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11-5 , 19 57 , to 12-8 , 19 57 , that I last saw the deceased alive on 12-8 , 19 57 , and that death occurred at 1:30P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE L Brings M.D.		ADDRESS (Street, city or town, state) 57 Greene St., Cumberland, Md. DATE SIGNED 12/9/59	
PHYSICIAN'S NAME (Type) LEWIS BRINGS		m.d. M.D. 57 GREENE ST., CUMBERLAND, MARYLAND	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/11/59	
22c. NAME OF CEMETERY OR CREMATORIUM Frostburg Memorial Park		22d. LOCATION (City, town, or county) (State) Frostburg Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		24a. REC'D BY REGISTRAR DATE DEC 14 '59	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

44

1968-1969. DONOR: VET

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Inv. No.: 1

Serial:

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1968-1969. DONOR: VET

1968-1969. DONOR: VET

1968-1969. DONOR: VET

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13206

CERTIFICATE OF DEATH

Reg. Dist. No.

PLACE OF DEATH

o. COUNTY

ALLEGANY

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

CUMBERLAND

c. LENGTH OF STAY IN 1b

14 DAYS

d. NAME OF HOSPITAL (If not in hospital, write address or institution)

WARRICK & MEMORIAL
MEMORIAL HOSPITAL AVES.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

o. STATE

MARYLAND

b. COUNTY

ALLEGANY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

22 FROSTBURG

d. STREET ADDRESS

1 137 SOUTH WATER ST.

e. IS RESIDENCE
ON A FARM?
YES NO 3. NAME OF
DECEASED
(Type or print)First
ALICEMiddle
K. R.R.Last
PARKER4. DATE
OF
DEATHMonth
DECEMBERDay
30
Year
1959

5. SEX

FEMALE

6. COLOR OR RACE

WHITE

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

JANUARY 30, 1913

9. AGE (In years
at birthday)
yrs.

46

10. IF UNDER 1 YEAR IF UNDER 24 HRS.

Months
DaysHours
Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housework

10b. KIND OF BUSINESS OR INDUSTRY

Own home

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

MC DONALD, ARCH

14. MOTHER'S MAIDEN NAME

SCHELLE, CHRISTINA

15. WAS DECEASED EVER IN U. S. ARMED FORCES?

(Yes, no, or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

212-18-1466

INFORMANT

Address

MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

251X

DUE TO

Ventricular fibrillation with terminal cardiac arrest, say 10 min.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

Chronic valvular heart disease, with mitral insufficiency, 5 years.

DUE TO

(c)

Respiratory, insufficiency

abnormalities. Death with thyroidectomy 24 Dec 59

INTERVAL BETWEEN
ONSET AND DEATH

MEDICAL CERTIFICATION

2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY

PERFORMED?

YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)

20c. TIME OF INJURY Month, Day, Year
Hour a. m.
p. m.20d. INJURY OCCURRED
While at work Not while at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from 20 Dec., 1959, to 30 Dec., 1959, that I last saw the deceased alive on 20 Dec. 1959, and that death occurred at 9:45 P.M., from the causes and on the date stated above.

ACTUAL
SIGNATURE

W. Alfred Van Ormer

M.D.

ADDRESS (Street, city or town, state)

DATE SIGNED
31 Dec 59PHYSICIAN'S
NAME (Type)

DR. W. A. VAN ORMER

22a. BURIAL, CREMATION,
REMOVAL (Specify)
Burial 1/3/59

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORY

22d. LOCATION (City, town, or county)

(State)

Frostburg Memorial Park

Frostburg

23. FUNERAL DIRECTOR'S SIGNATURE

Hafer Funeral Home

ADDRESS

24a. REC'D BY REGISTRAR

(State)

Bentley H. Minot 23 E. Main, Frostburg, Md.

DATE JAN 5 '60

24b. REGISTRAR'S SIGNATURE
Arthur S. Hafer

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13225

CERTIFICATE OF DEATH

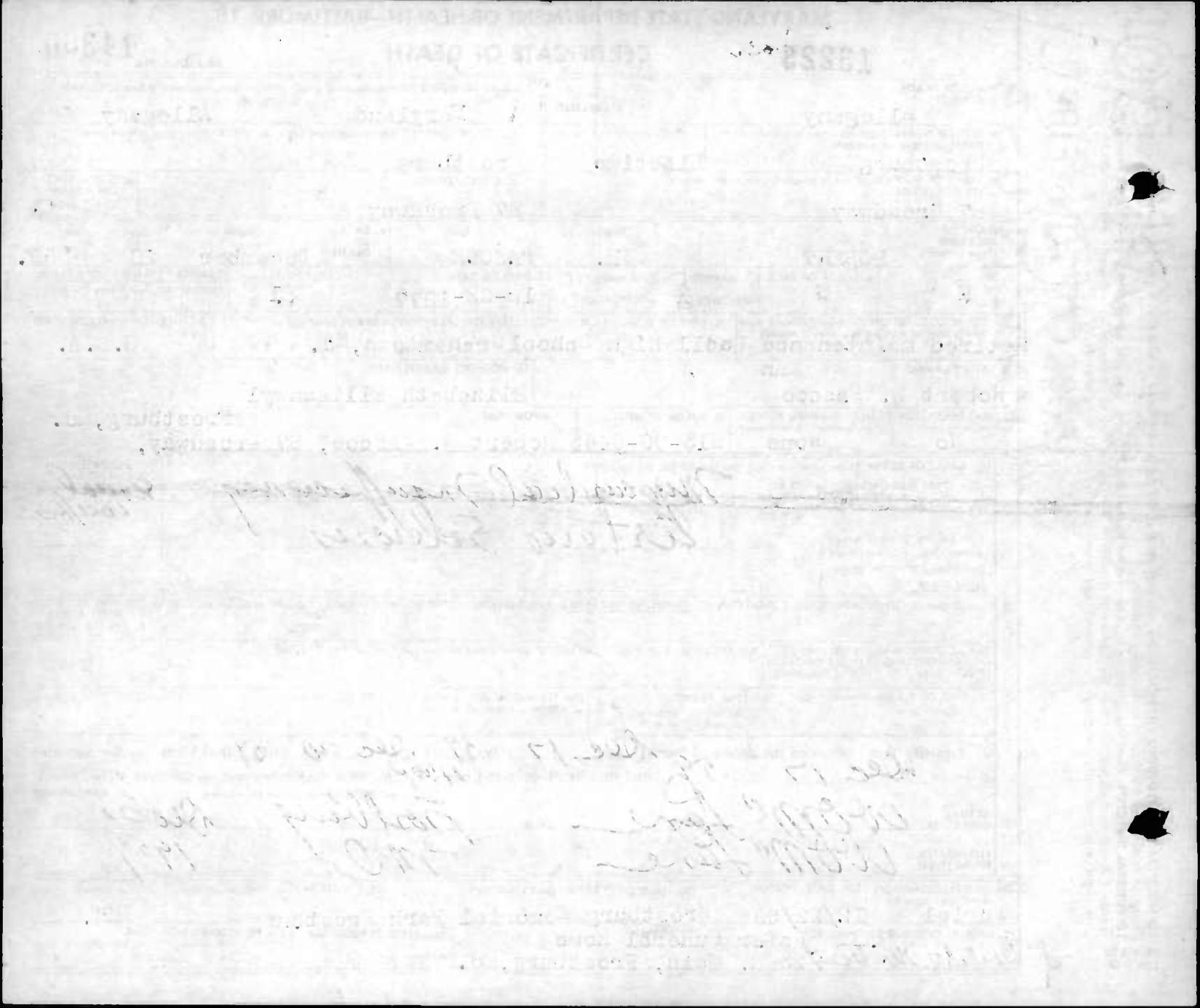
Reg. Dist. No.

14350

TO HOSPITAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b Lifetime	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 87 Broadway		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ROBERT	First H.	Middle PASCOE	Last December 20 1959
4. DATE OF DEATH 12-22-1877	Month December	Day 20	Year 1959
S. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-22-1877
9. AGE (In years last birthday) 81 yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired maintenance	10b. KIND OF BUSINESS OR INDUSTRY Baall High School	11. BIRTHPLACE (State or foreign country) Grahamtown, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.	13. FATHER'S NAME Robert W. Pascoe		
14. MOTHER'S MAIDEN NAME Elizabeth Ellisawyl	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No None		
16. SOCIAL SECURITY NO. 213-09-6445	INFORMANT Robert W. Pascoe, 87 Broadway	Address Frostburg, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH several weeks			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) Frostburg	
21. I certify that I attended the deceased from Dec 17, 1959 , to Dec 20, 1959 , that I last saw the deceased alive on Dec 17, 1959 , and that death occurred at 11:00 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE WOMC Lane		ADDRESS (Street, city or town, state) Frostburg, MD	
PHYSICIAN'S NAME (Type) WOMC Lane		DATE SIGNED Dec 22, 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/22/59	22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Frostburg Memorial Park	22d. LOCATION (City, town, or county) (State) Frostburg, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Benshitt. Minter		23. ADDRESS Hafer Funeral Home 23 E. Main, Frostburg, Md.	24a. REC'D BY REGISTRAR JAN 8 '60
		24b. REGISTRAR'S SIGNATURE Cynthia S. Krause	



TO HOSPITAL **ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13207 CERTIFICATE OF DEATH

Reg. Dist. No. 13207

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 10/23/58	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Emmanuel	Middle	Last Porter
4. DATE OF DEATH	Month December	Day 21, 1959	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/8/1869
9. AGE (In years lost birthday) 90 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Coal Miner	10b. KIND OF BUSINESS OR INDUSTRY Coal Mining	11. BIRTHPLACE (State or foreign country) Ellerslie, Maryland	12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Leonard Porter	14. MOTHER'S MAIDEN NAME Mary Lowery		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. If yes, give war or dates of service)	INFORMANT P.O.Box 599	Address Cumberland, Md.
17. ALLEGANY COUNTY INFIRMIARY RECORDS			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Endocardial Degeneration INTERVAL BETWEEN ONSET AND DEATH 592x			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral arteriosclerosis, - ?			
DUE TO (c) Chronic nephritis ?			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Senile Deterioration 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 10/23/58 , 19, to 12/21/59 , 19, that I last saw the deceased alive on 12/21/59 , 19, and that death occurred at 3:00 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>James E. McLean</i>		ADDRESS (Street, city or town, state) 49 Greene St. DATE SIGNED 12/21/59	
PHYSICIAN'S NAME (Type) Dr. James E. McLean		CUMBERLAND, MARYLAND	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12-24-59	22c. NAME OF CEMETERY OR CREMATORIUM Eckhart Cemetery	22d. LOCATION (City, town, or county) Eckhart (State) Md.
23. FUNERAL DIRECTOR'S SIGNATURE <i>Benj H Montecut</i>	ADDRESS Hafer Funeral Home 23 East Main, Frostburg, MD	24a. REC'D BY REGISTRAR DEC 28 '59	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Trahan</i>

1978-1979

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Geodesic curvature

Letters

2200 J. R. COOPER

“*Worship by Love*”

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13208

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 7 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL AVES.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First GEORGE		Middle E.	Last RUHL
4. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPTEMBER 9 1899
9. AGE (In years last birthday) 60	10. IF UNDER 1 YEAR Months 0 Days 0	11. IF UNDER 24 HRS. Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Electrician		10b. KIND OF BUSINESS OR INDUSTRY QUEEN City Electric	
11. BIRTHPLACE (State or foreign country) MARYLAND, Cumberland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME WILLIAM RUHL		14. MOTHER'S MAIDEN NAME SARAH HANKS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. WW1	
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i> DUE TO <i>Arteriosclerosis</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Coronary Artery Disease</i> DUE TO _____ (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>falling</i>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. — 19 p. m. —		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify, that I attended the deceased from 12/4/56 , 19, to 12/10/59 , 19, that I last saw the deceased alive on 12/27/59 , 19, and that death occurred at 1:45 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Richard Williams</i>		ADDRESS (Street, city or town, state) Cumberland DATE/SIGNED 12/27/59	
PHYSICIAN'S NAME (Type) DR. RICHARD WILLIAMS		122 South Center St. Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/30/59	
22c. NAME OF CEMETERY OR CREMATORIUM Rose Hill Cemetery		22d. LOCATION (City, town, or county) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		ADDRESS	
		24a. REC'D BY REGISTRAR DATE DEC 30 '59	
		24b. REGISTRAR'S SIGNATURE Arthur S. Hafer	

YU-24

ОДИУПЛ

YU-24

БАЛКОНОВ

РЫБА

ОДИУПЛ

ЧУДОВИЩЕ СИДЯЩЕЕ НА ПЛАНЕТЕ ЗЕМЛЯ

ЧУДОВИЩЕ СИДЯЩЕЕ НА ПЛАНЕТЕ ЗЕМЛЯ

СОВОДОВ

С

ЗОРОВ

ОДИУПЛ

ОДИУПЛ

ЧУДОВИЩЕ СИДЯЩЕЕ НА ПЛАНЕТЕ ЗЕМЛЯ

СИДЯЩЕЕ НА ПЛАНЕТЕ

ЧУДОВИЩЕ СИДЯЩЕЕ НА ПЛАНЕТЕ

13209

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13209 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Allegany				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb 5 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		d. STREET ADDRESS 433 Henderson Ave.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First George	Middle E.	Last Schute	4. DATE OF DEATH	Month Dec.	Day 5	Year 1959
5. SEX Male	6. COLOR OF HAIR White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 26, 1913	9. AGE (in years last birthday) 46 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Spinner.		10b. KIND OF BUSINESS OR INDUSTRY Celanese Corporation		11. BIRTHPLACE (State or foreign country) Cumberland, Md., U.S.A.		12. CITIZEN OF WHAT COUNTRY? Address	
13. FATHER'S NAME William Schute		14. MOTHER'S MAIDEN NAME Clara Martz					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes.		16. SOCIAL SECURITY NO. 114-07-3184		17. INFORMANT Mr. Clara Schute		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Portal Cirrhosis, Marked; Esophageal Varices DUE TO 581.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____	
INTERVAL BETWEEN ONSET AND DEATH Years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Hydrothorax, bilateral; Ascites, marked.							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Cumberland	(County) Md.	(State) Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Benedict Skitarelic	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						DATE SIGNED December 5, 1959
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.	DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/9/59	22c. NAME OF CEMETERY OR CREMATORIAL St. Peter & Paul Cemetery	22d. LOCATION (City, town, or county) Cumberland, Md. (State) Md.				
23. FUNERAL DIRECTOR'S SIGNATURE Louis Stein Inc. Cumb. Md.	ADDRESS	24a. REC'D BY REGISTRAR Dec 8 '59		24b. REGISTRAR'S SIGNATURE Arthur J. Tracy			

STATE OF SOUTH DAKOTA
EXCAVATION PERMIT

Permit No.	Examiner's Name	Date Issued
100-00000000	John Doe	01/01/2023
Address of Site		
123 Main Street, Anytown, SD 57401		
County		
Pennington County		
Description of Work		
Excavation for a new foundation for a residential building.		
Start Date		
01/01/2023		
End Date		
01/31/2023		
Duration		
30 days		
Permit Type		
General Excavation Permit		
Permit Holder		
John Doe		
Signature		
John Doe		
Comments		
None		

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13210 CERTIFICATE OF DEATH

13210

Reg. Dist. No.

- ① HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
- ② FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 9 HRS. 25 MIN.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND				
d. NAME OF HOSPITAL (If not in hospital, give street address) MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.			d. STREET ADDRESS 233 CUMBERLAND STREET					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print)		First BABY	Middle GIRL	Last SHAFFER	4. DATE OF DEATH DECEMBER 28 1959			
5. SEX FEMALE		6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 28, 1959	9. AGE (In years last birthday) yrs. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant	10. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) CUMBERLAND, MD.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME THOMAS P. SHAFFER				14. MOTHER'S MAIDEN NAME PATRICIA A. KIRK				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. None		INFORMANT MEMORIAL HOSPITAL		Address CUMBERLAND, MARYLAND		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Circulatory Failure due to Hematuria</i> 776 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) CUMBERLAND	(County) MARYLAND	(State) MARYLAND
21. I certify that I attended the deceased from <i>18 Dec</i> , 1959, to <i>28 Dec</i> , 1959, that I last saw the deceased alive on <i>28 Dec</i> , 1959, and that death occurred at <i>9:47 AM</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE <i>Leland B. Dawson</i> M.D. <i>63 Green St, Cumberland, Md</i> DATE SIGNED <i>29 Dec 59</i>								
PHYSICIAN'S NAME (Type) DR. RANSOM								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/30/59	22c. NAME OF CEMETERY OR CREMATORIUM SS. Peter & Paul's			22d. LOCATION (City, town, or county) Cumberland, Maryland			(State) MARYLAND
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George Cumberland, Maryland			ADDRESS		24a. REC'D BY REGISTRAR DATE DEC 31 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13211

CERTIFICATE OF DEATH

Reg. Dist. No.

13211

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 7 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sylvan Retreat				d. STREET ADDRESS 1 Gay Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Herbert	Middle Raymond	Last Shanholtz	4. DATE OF DEATH Month December	Day 29	Year 19 59
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Sept. 4, 1893		9. AGE (In years last birthday) 66 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Roofing		10b. KIND OF BUSINESS OR INDUSTRY Building Contr.		11. BIRTHPLACE (State or foreign country) West Virginia, Agustia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Shanholtz				14. MOTHER'S MAIDEN NAME Laura Arnold			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-05-6788		17. INFORMANT Mrs. Allie Burge		Address 22 Browning St.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422 Chronic Hypertensive Degeneration DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 450 General Arteriosclerosis. ? DUE TO (c) 581 Cirrhosis of Liver. ? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 304 Severe psychosis. -							
INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 21st 1959, to Dec. 29th 1959, that I last saw the deceased alive on Dec. 28th, 1959, and that death occurred at 1:30 A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE James E. McLean, M.D. 49 Greene St. -							
PHYSICIAN'S NAME (Type) James E. McLean, M.D. 49 Greene St., Cumberland, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-31-59		22c. NAME OF CEMETERY OR CREMATORIUM Restlawn Cem.		22d. LOCATION (City, town, or county) Cumberland, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli Cumberland, Md.				ADDRESS		24a. REC'D BY REGISTRAR DATE JAN 4 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

may be retained by the hospital or attending physician and completely filled in by the funeral director.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.VS A15 (4)
15M 10/57

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13226

CERTIFICATE OF DEATH

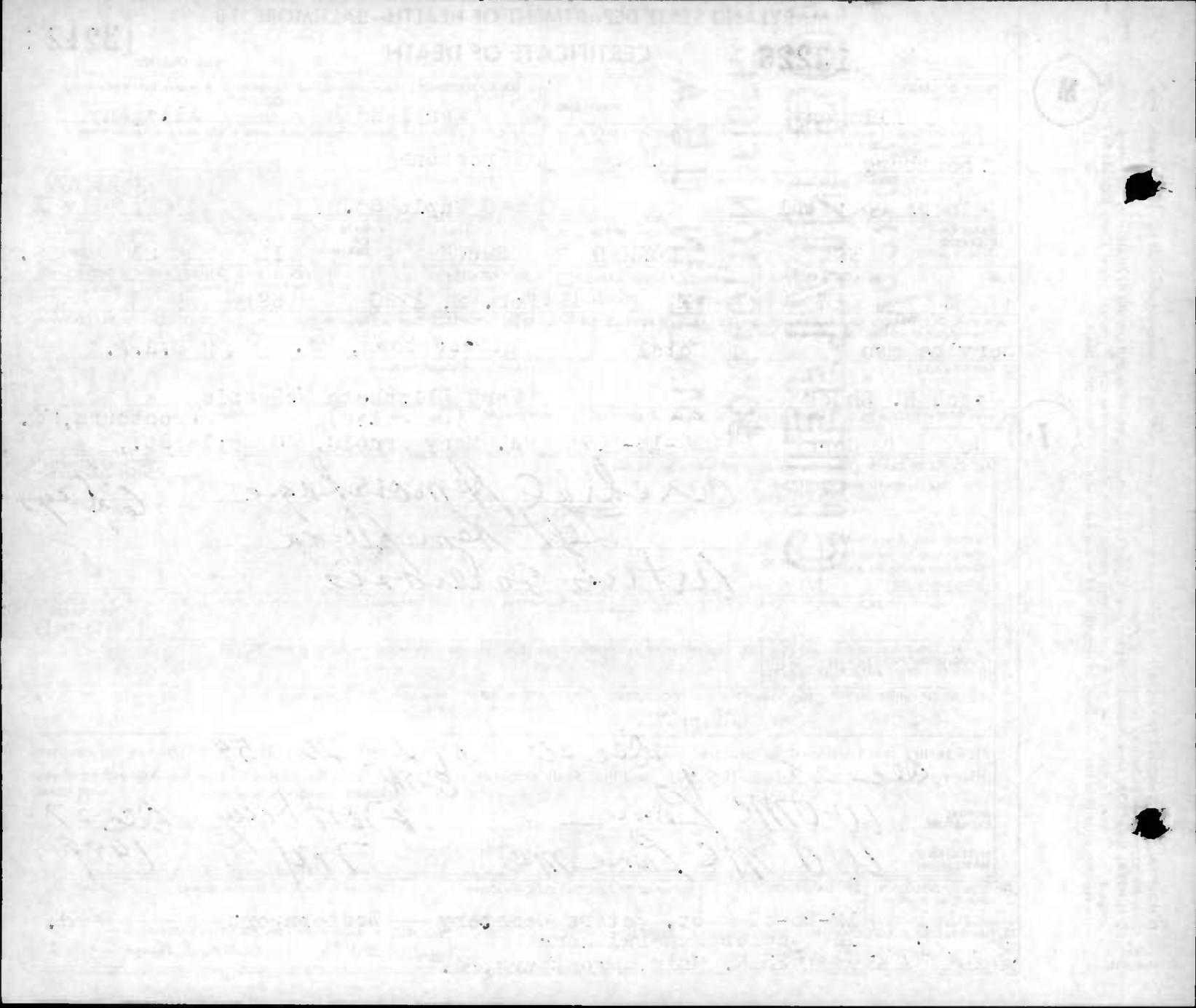
13212

Reg. Dist. No.

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN lb 6 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First JOHN	Middle CONRAD	Last SHUCK
S. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 2, 1890
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Service man		10b. KIND OF BUSINESS OR INDUSTRY Hotel	
11. BIRTHPLACE (State or foreign country) Cresaptown, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jacob H. Shuck			
14. MOTHER'S MAIDEN NAME Mary Elizabeth McKenzie			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	INFORMANT (Daughter) Mrs. Mary Arnold, 40 Maple St.,	Address Frostburg, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)			
<i>Cerebral Hemorrhage</i> <i>Left Hemiplegia</i> <i>Arteriosclerosis</i> INTERVAL BETWEEN ONSET AND DEATH 6 Days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Dec 20 , 1959, to Dec 26 , 1959, that I last saw the deceased alive on Dec 25 , 1959, and that death occurred on Dec 25 AM, from the causes and on the date stated above. ACTUAL SIGNATURE WOMC Lane PHYSICIAN'S NAME (Type) WOMC Lane, MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12-28-59	22c. NAME OF CEMETERY OR CREMATORIUM St. Peters Cemetery	22d. LOCATION (City, town, or county) Westernport
23. FUNERAL DIRECTOR'S SIGNATURE Benah H. Whiteside	ADDRESS Hafer Funeral Home 23 E. Main, Frostburg, Md.	24a. REC'D BY REGISTRAR DEC 30 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13212

CERTIFICATE OF DEATH

Reg. Dist. No.

13213

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Maryland c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 60 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 504 Montreal Ave.		d. STREET ADDRESS 504 Montreal Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Sarah	Middle A.	Last Sweitzer
4. DATE OF DEATH	Month Dec.	Day 1	Year 19 59
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Nov. 7, 1874
9. AGE (In years lost birthday) 85	10. IF UNDER 1 YEAR Months 85	11. IF UNDER 24 HRS. Days 0	12. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Little Orleans, Md.	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME John F. Apple		14. MOTHER'S MAIDEN NAME Hannah Slider	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. none	17. INFORMANT Mr. Arch M. Sweitzer, Cumberland, Md.	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocarditis & Deconsolidation		INTERVAL BETWEEN ONSET AND DEATH 6 weeks	
Conditions, if any, which gave rise to immediate cause (a), slotting the under- lying cause lost. (b) 422.2 DUE TO Myocarditis & Deconsolidation DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.	Month Dec. Day 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> At work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Dec. 1, 1957 , to Dec. 1, 1959 , that I last saw the deceased alive on Dec. 1, 1959 , and that death occurred at 3:55 p.m. , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Clay E. Durrett</i>	ADDRESS (Street, city or town, state) 236 Virginia Ave.		DATE SIGNED 12-2-1959
PHYSICIAN'S NAME (Type) Dr. Clay E. Durrett, MD	Cumberland, Md.		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec. 4, 1959	22c. NAME OF CEMETERY OR CREMATORIUM Rose Hill Cemetery	22d. LOCATION (City, town, or county) (State) Cumberland, Md.
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.	ADDRESS	24a. REC'D BY REGISTRAR DEC 4 59	24b. REGISTRAR'S SIGNATURE Arthur S. Head

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

13214

13213

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 6/4/1954	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First AMY	Middle ETHEL	Last Tee
4. DATE OF DEATH December 30, 1959	Month Year	Day	Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/2/1891
9. AGE (In years last birthday) 68 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Months 0	12. IF UNDER 24 HRS. Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Waitress in Restaurant	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Pennsylvania	12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Phillip S. Imes	14. MOTHER'S MAIDEN NAME Leyina Trail		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO.	INFORMANT P.O.Box 599	Address Cumberland, Md.
Allegany County Infirmary Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			
<i>422.1</i>			
DUE TO			
<i>Chronic Myocarditis</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)			
<i>Cerebral Hemorrhage</i>			
DUE TO			
<i>General Arteriosclerosis</i>			
C. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
<i>Hypertension</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/4/54 , 19, to 12/30/59 , 19, that I lost sow the deceased alive on 12/30/59 , 19, and that death occurred at 7:00P.M. from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) 49 Greene St. DATE SIGNED 12/31/59			
ACTUAL SIGNATURE <i>James E. McLean</i> M.D.			
PHYSICIAN'S NAME (Type) Dr. James E. McLean		Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/2/60	
22c. NAME OF CEMETERY OR CREMATORIALy		22d. LOCATION (City, town, or county) (State) Zion Memorial Cem. Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George		ADDRESS Cumberland, Maryland	24a. REC'D. BY REGISTRAR JAN 5 60 DATE
		24b. REGISTRAR'S SIGNATURE <i>Charles L. George</i>	

Fluorite

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

13215

13214

1. PLACE OF DEATH a. COUNTY ALLEGANY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 5 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X LA VALE, MARYLAND			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		d. STREET ADDRESS /		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	BERTIE	Middle M.	Last THOMAS	4. DATE OF DEATH	Month DEC.	Day 13	Year 1959
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/20/1879	9. AGE (In years last birthday) 80 yrs.	IF UNDER 1 YEAR Months 80	IF UNDER 24 HRS. Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) FROSTBURG, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHARLES SAURBAUGH				14. MOTHER'S MAIDEN NAME JANE ANGWIN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO <i>Arterio sclerotic cordis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <i>vascular disease?</i> (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12-8 , 19 59 , to 12-13 , 19 59 that I last saw the deceased alive on 12-10 , 19 59 , and that death occurred at 1:30 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Wm. F. Williams</i>	ADDRESS (Street, city or town, state) Cumberland, Md.						DATE SIGNED 12/15/59
PHYSICIAN'S NAME (Type) DR. W. F. WILLIAMS	122 So. Centre St. Cumberland, Md.						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/15/59	22c. NAME OF CEMETERY OR CREMATORIAL Frostburg Mem. Park			22d. LOCATION (City, town, or county) Frostburg, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland				ADDRESS		24a. REC'D BY REGISTRAR Arthur S. Kraus	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus
				DATE DEC 21 '59			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13216

13213

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 47 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 918 Maryland Avenue		e. STREET ADDRESS 918 Maryland Avenue	
3. NAME OF DECEASED (Type or print) Ernest		First Marshall	Middle Thomas
4. DATE OF DEATH December 22 1959	Month December	Day 22	Year 1959
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Sept 10, 1888
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Charge hand- Acetate dept		10b. KIND OF BUSINESS OR INDUSTRY Celenese	11. BIRTHPLACE (State or foreign country) West Virginia
13. FATHER'S NAME David Thomas		14. MOTHER'S MAIDEN NAME Flora Dicken	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW I 214-07-4608	17. INFORMANT Mrs. Mabel Thomas
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1		INTERVAL BETWEEN ONSET AND DEATH Death	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO myocarditis & Decongestion		6 mos	
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June , 1959, to Dec 22, 1959 , that I last saw the deceased alive on Dec. 21, 1959 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 236 W. Carrollton Road		DATE SIGNED 12/23/59	
ACTUAL SIGNATURE Cloud Garrett		M.D.	
PHYSICIAN'S NAME (Type) Ruth E. Silcox			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/24/59	22c. NAME OF CEMETERY OR CREMATORIUM Greenmount Cemetery	22d. LOCATION (City, town, or county) Cumberland Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Ruth E. Silcox		ADDRESS Cumberland Maryland	24a. REC'D BY REGISTRAR DATE DEC 28 '59
			24b. REGISTRAR'S SIGNATURE Arthur S. Kline

81. BROWNSTONE—FLASH TO TENTH AND STATE CHARTERED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13216

Item 16, Film G-253 12/28/59.cac

Reg. Dist. No.

13217

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 40 Years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 320. Reservoir Ave		e. STREET ADDRESS 320 Reservoir Ave..	
3. NAME OF DECEASED (Type or print) James Harrison Thompson		First James	Middle Harrison
Last Thompson		4. DATE OF DEATH Month December	Day 15
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 17 1888
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		10b. KIND OF BUSINESS OR INDUSTRY Constituion Park	11. BIRTHPLACE (State or foreign country) Morgan Co, West Va.
13. FATHER'S NAME George Thompson		14. MOTHER'S MAIDEN NAME Mary Hines	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes		16. SOCIAL SECURITY NO. 6905 220 16 6950	17. INFORMANT Address Ward L, Thompson 320. Reservoir Ave City
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Coronary Occlusion			
DUE TO 420.1			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Sclerosis			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>	DATE SIGNED M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> December 15, 1959		
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec 18 1959	22c. NAME OF CEMETERY OR CREMATORIUM Zion Memorial Park	22d. LOCATION (City, town, or county) Cumberland, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Byron Kight		ADDRESS Cumberland, Md.	24a. REC'D BY REGISTRAR DATE DEC 21 '59
			24b. REGISTRAR'S SIGNATURE <i>Collins P. Kight</i>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "Pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the signature, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 13217 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13218

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)		a. STATE Maryland b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Cumberland		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		
				50 Years		Cumberland		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		4 Altamont Terrace		d. STREET ADDRESS		4 Altamont Terrace		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print)		First Mary	Middle Ann	Last Topper	4. DATE OF DEATH	Month December	Day 10	Year 1959
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH	9. AGE (in years on birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
Female		Whites	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	April 29 1875	84 yrs.	Months	Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
House		House Wife		Lonaconing, Md.		USA		
13. FATHER'S NAME		John Wright		14. MOTHER'S MAIDEN NAME		Hannah Boden		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT		Address		
		None		Allen Boyer, 4. Altamont Terrace		Cumberland, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Coronary Occlusion						
420.1 DUE TO								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)								
DUE TO		Coronary Sclerosis						
(c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
19								
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>						
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.		DATE SIGNED						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial Dec 12 1959		22b. DATE THEREOF Dec 12 1959		22c. NAME OF CEMETERY OR CREMATORIAL Sunset Memorial Park		22d. LOCATION (City, town, or county) Cumberland, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Byron Kight		ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR DATE DEC 14 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur J. Kraus</i>		

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 13219

1. PLACE OF DEATH
o. COUNTY

Allegany

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL
and give nearest town)

Rt. # 6 Cumberland.

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

429 Ave., M. Potomac Park

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)

o. STATE Maryland

b. COUNTY Allegany

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

X Rt. # 6 Cumberland.

d. STREET ADDRESS

429 Ave., M. Potomac Park

e. IS RESIDENCE
ON A FARM?YES NO 3. NAME OF
DECEASED
(Type or print)First
CHARLES

Middle

Last

4. DATE
OF
DEATH
DECEMBER # 31 19 59

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

Nov. 13, 1880

9. AGE (In years
at birthday)77
yrs.

IF UNDER 1 YEAR

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

Retired farmer

10b. KIND OF BUSINESS OR INDUSTRY

Farm owner

11. BIRTHPLACE (State or foreign country)

Rockingham Co. Va.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Millard Turner

14. MOTHER'S MAIDEN NAME

Rebecca Kesner

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)

No,

16. SOCIAL SECURITY NO.

17. INFORMANT

Mr. Harold Turner Potomac Park, Cumb. Md.

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

CORONARY OCCLUSION

INTERVAL BETWEEN
ONSET AND DEATH

SUDDEN

420.1

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

CORONARY SCLEROSIS

MEDICAL CERTIFICATION

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY
PERFORMED?YES NO 20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m.20d. INJURY OCCURRED
While at work Not while at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry , and find that death resulted from: Natural causes Accident Suicide Homicide Undetermined cause ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Benedict Skitarelic

M.D. CHIEF MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER

DATE SIGNED

22a. BURIAL, CREMATION,
REMOVAL (Specify)
Burial22b. DATE THEREOF
1/3/6022c. NAME OF CEMETERY OR CREMATORIUM
Lahmansville Cemetery22d. LOCATION (City, town, or county)
(State)
Lahmansville, W. Va.

23. FUNERAL DIRECTOR'S SIGNATURE

Charles L. George Cumberland, Md.

ADDRESS

24a. REC'D BY REGISTRAR
DATE JAN 5 '6024b. REGISTRAR'S SIGNATURE
C. L. George

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse the certifying, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit Permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

V.S. A15ME(5)
SM 9/55

MARYLAND STATE POLICE DEPARTMENT - BALTIMORE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

SEARCHED	INDEXED	SERIALIZED	FILED
DECEASED PERSON			
NAME			
ADDRESS			
AGE			
SEX			
RACE			
WEIGHT			
HEIGHT			
HAIR COLOR			
EYE COLOR			
CLOTHING			
JEWELRY			
ACCOMPLISHMENTS			
EXPLANATION			
CAUSE OF DEATH			
TIME OF DEATH			
TIME OF AUTOPSY			
TESTIMONY			
EXAMINER'S SIGNATURE			
APPROVING OFFICER'S SIGNATURE			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

13280

13218

1. PLACE OF DEATH o. COUNTY Allegany		MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland	b. COUNTY Allegany
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 3/3/58	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Flintstone	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		d. STREET ADDRESS Route #1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print)	First Rebecca	Middle Wood	Last Wathon	4. DATE OF DEATH Month December Day 9, Year 19 59
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/10/1874	9. AGE (In years at birthday) 85 yrs. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Office Worker		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Uniontown, Pennsylvania
13. FATHER'S NAME Henry Wathon		14. MOTHER'S MAIDEN NAME Elizabeth Howser		12. CITIZEN OF WHAT COUNTRY? U. S. A.
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		INFORMANT P.O. Box 599 Address: Cumberland, Md. Allegany County Infirmary Records
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 592 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)				
<i>Chronic Myocardial degeneration</i> Sudden <i>Cerebral Arteriosclerosis.</i> > <i>Chronic Nephritis.</i> ?				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) Severe Deterioration.				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 3/3/58 , 19, to 12/9/59 , 19, that I last saw the deceased alive on 12/8/59 , 19, and that death occurred at 4:00A M, from the causes and on the date stated above.				
ADDRESS (Street, city or town, state) 49 Green St., Cumberland, Md. DATE SIGNED 12/9/59				
ACTUAL SIGNATURE <i>James E. McLean</i> M.D.				
PHYSICIAN'S NAME (Type) Dr. James E. McLean Cumberland, Md.				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 11, 1959	22c. NAME OF CEMETERY OR CREMATORIUM Rose Hill Cemetery	22d. LOCATION (City, town, or county) (State) Cumberland, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Byron Kight		ADDRESS Cumberland, Md.	24a. REC'D BY REGISTRAR DATE DEC 14 '59	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>

11861

REASISTANT CEDAR

21881

VANILLA

BASIL

VANILLA

enclosed

RE\CE

bushes

I know

enclosed some vanilla

X

92

P redwood

norish

book

seedbed

20

4784\01\6

mid May plant

11.0 sunburned branches

seedling - hardy

cauliflower

norish tress

bushes

abnormal growth in plants

some

on

TS

it

RE\TS

RE\TS

RE\TS

the next 6d

dry brushwood

water + soap +

sunburned

green leafy leaves before

the first frost